10-04041	
Charles Sisco	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

harles Sisco		State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg No.	0											
Physicia ledical Exami	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year												
7		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Johns Hopkins Hospital  4c. County of Death  Baltimore												
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Annumber 1 Annumber 2 Annumber 2 Annumber 3 Annu												
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	1 / hadra M Sign. Str   Stalla Bates												
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "nat injury or other traumatic event, the Medical Exa	To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20a. Method of Disposition  10b. Place of Disposition (Name of cemetery, or other place)  20b. Place of Disposition (Name of cemetery, or other place)  20b. Place of Disposition (Name of cemetery, or other place)  20c. Location - City or Town, State  20c. Location - C												
Physician /Medical Examiner	niner	23a. Part I/Enterithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Meart failure. Lisyonly one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Couse (Disease or injury that initiated cause).												
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and e funeral director, page 2 should be detached for use as the burial - transit	Completed by Physician/Medical Exam	Physician/Medical	by Physician/Medical	sician/Medical	Physician/Medical	events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED  PII per ME g904 6/23/10 TT   23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in Part I.  23d. Date of delivery Month Day  Year  23d. Date of delivery Month Day  Year	1?							
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach				24a. Was an autopsy findings ava prior to completion of cause death?  1 ✓ Yes 2 No 1 ✓ Yes 2 N	ilable e of									
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seen in the funeral director, page 2 should the fine that the funeral director, page 2 should the fine that the funeral director, page 2 should the fine that the funeral director, page 2 should the fine that the funeral director, page 2 should the fine that the fine the fine that the fine that the fine that the fine that the fine the fine the fine that the fine that the fine that the fine t	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  128a Date of Injury 28b. Time of Injury 28c. Injury at Work?  128d. Describe how injury occurred	City											
Division  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the f	Medical Cer	1 /98 Definite	_											
	Σ	29b. Signature and title of certifier  O.C.M.E.  29d. Date signed (Month, Day, Year)  May 28, 2010  30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201												
St	ate	Of Switch the state of the stat												

DHMH 17 Rev 1/2001 OCME 2006

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		1- For Amend Items 23aPtI, TIY per de Registrar	eparinantal Certificate of Dea	<b>20 20 d M</b> en ath	tal Hygier Reg. N	e 2010	8502
Physici		1. Decedent's Name (First, Middle, Last)  Roland Hilton Und	rwood		ate of Death Month	29 20\0	3. Time of Death
/Medic Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Locat			C. County of Peath	indel
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit		nder 24 Hrs. 8. D	Date of Birth Month, Day, Yea	9. Birth	place (State or Foreign
70		365-30-7524	n or Location	,00.	1 21, 1		10d. Inside City Limits
ne Maryl 8a-f sho	ector	MD Anne Arundel	Annapol:	is	1.40	Division of Miles A Court	1 ☐ Yes 2 XNo
h with th	al Dir	961 Running Brook Way	10f. Zip Code 214	401	10g. (	Citizen of What Cou USA	ntry:
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event and the Laboratic event, the Medical Event and the Laboratic event.	by Funeral Director	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 No Spe	ic Origin? (Specify exican, Puerto Rica ecify:	Yes or No- n, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
altimore, Maryland 21215-0036 rmit. Pages 1 and 2 should be filled within 72 hours at partment of Health and Mental Hyglene. portant: If Item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Event. & the Westell Event.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Industrial Desia			Kind of Business/Ir	dustry
yland 2:  yld be filed v Mental Hygic arked other i	Be Co	17. Father's Name (First, Middle, Last)		Mother's Name (Fin			Design
aryla should to the Ment marked umatic e	2	Harold Underw  19a. Informant's Name/Relationship (Type. Print)  19b.	CCC  Mailing Address (Street and N.	Elizabet Jumber or Rural Ro			tWOUt
and 2: and 2: Health a m 27 is her trau			1 Running Brook	k Way A		s, MD 21	
more Pages 1 ment of H mut: If Ite		1 Buriai 2 LaCremation 3 Li Removal from State 1	f Disposition (Name of ry, crematory or other place)  Crematory, Inc			ltimore,	
Baltimore, permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other		21. Signature of Funeral Service Licensee George MacNabb		Facility Crema	tion So	ciety of imore, MD	MD, Inc. 21228
Physician /Medical	8. 1	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.	Jr Renil	ch as cardiac or res	Spiratory arrest,		Approximate Interval Between Onset and Death 2 day
Examiner		Due to (or as a consequence  Dehye	on: dration				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	oij.				
8760, cate be executed physician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence					
x 687 sertificat ding phy	Medic	IF FEMALE: 23c. If yes, outcome of pregnancy					
P.O. Box 6i at the death certific by the attending p trached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	Day Year
cords, F w requires that been signed I should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in Atrial Fibrillation	n the underlying cause given in F	Part I.	23e. Did tobacc		the cause of death?
The la	Completed				24a. Was an autopsy performed 1 □ Yes 2 □	?// death?	opsy findings available ompletion of cause of
of Vital F Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Othor	Place of Death (CI  Nursing Home		e 6 □ Other (Spec	sify)
on of	tion: T	1 Natural 5 Pending (Month, Day, Year)	Time of 28c. Injury at Work?  M 1 □ Yes		Describe how in	njury occurred	
Division pital or Attend ours after death eral Director: /	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)		28f.	Location (Stree City or Town, Si	t and Number or Ru late)	ral Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	e, death occurred at the time, da nd/or investigation, in my opinior	ate and place, and n, death occurred a	due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and little or certifier	29c. License num	nber 27 4.45	29d.	Date signed (Month	) Day, Year)
(16)		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	12	An	Acorbi	m
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	have	11)10	, //	10 17/20/13	) 11/1/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 30 per dvr. 2904 6-14-10 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 2010 Decidance Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 D F Months Days Hours Min. Month, Day, Ye Country) Director 16-58-Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🗌 Widowed 4 🗆 Divorced "natural" Mite Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 19 Be 18. Mother's Name (First, Middle, Maiden Surname)
Helen Mraz 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Datewok ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Friday rvice Licenses 18434 22. Name and Address of Facility P 23a. Part 1 Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest/ Approximate shock of heart failure. List only one cause on ch line Interval Between Immediate Cause (Final Onset and Death **Syrysician**, disease or condition resulting in death) Medical Due to (or as consequence of) Examiner Sequentially list conditions, Examine rt ary, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 9 Unknown To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the tuneral director, page 2 should be detached. 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XW0 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BV Robyn Anderson 1221 Mercantile Lane Largo, Md. 20774

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year) ----

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8<sup>Day</sup> 2010<sup>Year</sup> Physician/ Month June Ethel O. Alexander 3:33 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, arch 3 1 M 2 F 579-22-8984 94 Director March 1916 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 🔎 No MD Baltimore Monkton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Manor Brook Rd. 21111 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify:white Completed 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medical Insurance n/a Sales Rep. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Grover G. Eakin Louie Gray Looney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lynn Moore/daughter Manor Brook Rd., Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/12/10 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens 4 Donation 5 Other (Specify) Timonium, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 J. Flagi Machael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition MENTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Yea 4 Pregnant at time of death 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 ☐ Yes 2 No HOSPICE ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier √ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29c. License number D 4 4 3 9 5 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

6701 N CHARLES ST, SUITE 4105 BALTIMITIEMA 21264

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility plame (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) Director 161 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [ USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc 1 Never Married 2 Married þ Baltimore, Marvland 21215-0036 1 🗆 Yes 2 🗹 No Completed 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden မ am 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or न Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or off 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee Funcial Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of,: ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Be Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Man of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after deatl To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tife of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YLAND GENERAL

Registrar
DHMH 17 Rev 7/2009

State

32. Registr

10-04340 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adnan Al-Katib State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner 1637 hrs Adnan Al-Katib June 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3004 O'Donnell Street Baltimore 5. Social Security Number unk 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY Director Months Days 1 M 2 F 66 May 15, 1944 Usual Residence of Decedent 10a State any 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD s 23a or 28a-f shov e notified at once. Baltimore X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 3004 O'Donnell Street 21224 USA Funeral 11. Marital StatusUNK 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)unk Armed Forces? unk White, etc.  ${
m unk}$ 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: the Medical Examiner Specify or Dates:

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done ${
m un}_{
m s}$  16b. Kind of Business/Industry ${
m unk}$ during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) unk If item 27 is marked her traumatic event, ? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P Anthony Zayas/police officer 5710 Eastern Avenue; Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 XO her Specify: in state Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Board; 655 W. Baltimore Street un Maryland 21201 Baltimore. I. Enter the disease or conflictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval List only one cause on each line /Medical Between Onset and a Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has certificate Yes 2 ✔ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? lospital: 1 Other Nursing Home 5 Residence 6 V Other: Scene this Inpatient ER/Outpatient 3 DOA 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, D) trar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VO 6 20:5h Medical cility Name (if not institution, give street and number County of Death **Examiner** 4b. City, Town, or Location of Death 1,WB last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 Months Hours Min. (Month, Day 3011th Carolina Director Usual Reside 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2 □ No 10e. Street and Number ō 10g. Citizen of What Country? Funeral 23a 1. angFord items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 M "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: Specify: Black 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) KESTAURANT 00K Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည NKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Brown balt. Jimmy 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 6-17-10 Lansdowne, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Pacility The Derrick C. Jones F. H., P.A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as our lac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final by Onset and Death Physician/ LOUNG disease or condition Medical resulting in death) Due to (or a a consequence of Examiner Sequentially list conditions Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of -transit and Due to (or as a consequence of): resulting in death) Last physician a Completed by Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Pregnant at time of death signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably After this certificate has been si funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital ٥ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
(Month, Day, Year) 28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 Accident 3 Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatui 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) Name and add 2000 West State Registrar

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T	homas Allan B	osto		ate of Maryla				nd Mer	ital Hyg	iene	J
_			1- For State Registrar  1. Decedent's Name (First, Middle	o Loot)	Cei	rtificate d	of Death		Lo		eg. No
Λ	Physici ledical Exami		and the second s							Date of Dea Month June 12, 2	Day
1			4a. Facility Name (if not institution		ımber)	-	4b. City, Town,	or Location		dic 12, 1	4
6			2300 Block of Kirk Ave				Baltimore				
1	Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ear If Und		Date of Bi	
2	Director		217–80–1782 Usual Residence of Decedent	1 <b>X</b> M 2 F	51	Y	rs.			Feb.0	4, 1
	any		10a. State 10b. County			Town or Loca					
	and show	ō	Maryland Balti	more Cour	ity Co	ckeysv	ille				
	r death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	10e. Street and Number	ah Dood			10f. Zip Code	1030			0g. Cit
	th the 23a ou		10514 Long Bran								Uni
	ath wi items	Funeral	11. Marital Status 1 Never Married 2 K Ma	Armed F		S. 13, W	Vas Decedent of F Yes, specify Cub	fispanic Ori an, Mexicar	gin? ( Speci ı, Puerto Ric	fy Yes or No an, etc.)	)-
	fter de	by Fu	3 Widowed 4 Dive	1 Yes	2 X No	1	Yes 2X	lo specify.			
	nours a		15. Decedent's Education (Spec			16a. Decede	ent's Usual Occup most of working li	ation (Give	kind of work	done	16b.
	36 in 72 l	plet	Elementary/Secondary (0-12)	College (		uai ii g	Home P				
	d with	Completed	17. Father's Name (First, Middle,		A		110110 1		's Name (Fi	rst, Middle, I	Maiden
	215 be file ntal Hj rked o	Be	Thomas Allen Bo	ston, Sr.					a Luci		
	21 hould of Mer is ma	٩	19a. Informant's Name/Relationsh			1	ng Address (Str				
	y, MD 21215-0036 and 2 should be filed within 72 hours after feath and Mould be filed within 72 hours after theat 1's marked other than "natural", traumatic event, the Medical Examiner		Mr. Anthony J.  20a. Method of Disposition	Boston (E			3 Wilson			arkvil	1e,
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Memtal Hygiens Department of History and Memtal Hygiens I friem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 Cremation	3 Removal fr			ther place)		June 1		200.
	Itim tit. Pa trimen ortant		4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:		rematio	n Services				Fo
	Balti permit. Departm Imports injury o		Fiften F.	Tar.	A Ir GIL	,Sc.   K	Name and Addrest Alexandre Addrest Alexandre Address Alexandre Address			reral & ium, Mar	
	Physician		23d. Part I. Enter the disease, or a failure. List only one cause	complications that c	aused the death.	Do not enter			ardiac or re	spiratory arr	est, sho
	/Medical Examiner		Immediate Cause (Final disease		one int	oxicat	ion				
			or condition resulting in death)	Due to (or as a	consequence of	"):					
		je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	):	-				
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	cuted nd transit	Ĕ	events resulting in death) Last	d	1	,					
	i <b>0,</b> e be executed ysician and burial - transit	dical	M UNPENDED	AMENDED	27 28a-	f ner	ME g905	7/1/	10		
	3760 ficate g phys s the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of pregr	nancy					230
	Box 6876 c death certificate the attending phy	Physician/M	past 12 months?	4 Pregn	ant at time of dea	oth -	etal death 3 Other (Specify)	Ectopic	pregnancy		
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	P.O. es that the gened by	J.	Part II. Other significant condition	ons contributing to	death but not re	sulting in the	underlying cause	given in Pa	ırt I.	23e. Did to	obacco 2
	ds, I	ted		<del></del>						24a. Was a	
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	Re: The ificate		25. Was case referred to medical				00 Bi-	- (D#	/Ol	1 Yes	2 N
	/ital sician is cert	Be	examiner?	Hospital:	npatient 2	ER/Outpatier		Other	(Check only Nursing He		Reside
	Division of Vital Records, rad or Attending Physician: The law requires at ore determent. The taw requires a Director. After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	<u>ان</u>	1 Yes 2 No 27. Manner of Death	28a, Date		28b. Time of		ury at Work		I. Describe h	
	ion tendir eath. tor: A	Certification:	1 Natural 5 Pendi 2 Accident Invest		/10	unk	1	Yes 2X	No ui	nk	
	ivis lor At after d Direct	tific	3 Suicide 6 X Could	not be 28e. Place	e of Injury - At ho		eet, factory, office	building, et	c. 28f	Location (8 or Town, S 1K	Street a
5	D ospital hours uneral y fillec	Ce	4 Homicide determined	(0,000))	unk					_	
2	Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the fumeral director, page 2 should be detached for use as the burial - transit	ledical	(Check only	ysician: To the bes niner:On the basis o	of examination ar						
	To To	<u>6</u>	20h Giffeture and title of contifer	and manner s			Loo III				

ygiene	20	10	18508
	g. No.	. ~	
2. Date of Death Month June 12, 20		ır	3. Time of Death 1227 hrs
	4c. County	of Death	
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8. Date of Birth		Foreig	hplace (State or n Baltimore, untry) Maryland
			10d. Inside City Limits
			1 Yes 2 No
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ecify Yes or No- Rican, etc.)	14. Race White		can Indian, Black,
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vork done	Specify: 16b. Kind of Bu	siness/l	ndustry
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Rural Route Numb			
Date	20c. Location -	City or	Town, State
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r respiratory arres			Approximate Interval
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	23d. Date of		
ncy	Month	D	ay Year
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23e. Did toba	acco use contril	bute to t	he cause of death?
1 Yes	2 No 3	Prob	ably 4 🗹 Unknown
24a. Was an			opsy findings available
autopsy perform	ed? d	eath?	ompletion of cause of
1 ✓ Yes 2 only one)	No 1	<b>✓</b> Ye	s 2 No
	esidence 6	Other:	Scene
28d. Describe ho			

28f. Location (Street and Number or Rural Route Number, City

June 13, 2010

29d. Date signed (Month, Day, Year)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) State Registrar

29b. Şiğrlature and title of certifier

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ORIGINAL

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

lem Mame and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ <sup>Day</sup> 2010 June 10 7:46 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death AUIIM 7. Age (In yrs. last birthday)
9 | Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 D M 2 Months Days Hours Pennsylvania Director 167-16-7955 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medic I Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 🕅 Widowed 4 🗆 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Rudolph Impaciatore Antoinette Colucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important: If item 27 is F. Felix Tarasco/Nephew Bel Air, MD 21014 3 Village Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State June 4 Donation 5 Other (Specify) 2010 Timonium, MD 21. Signature of Funeral Se 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Flagle Michael J. 23a. Part 1. Enter the disease, of shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy page 2 should be detached for in the past 12 months?

1 Yes 2 No 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown Were autopsy findings available prior to completion of cause of death? 24a, Was an or Attending Physician; The law autonsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) June 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 Susan S. Meltzer M.D., 1 Texas Station Road, suite 210, Timonium, MD 31. Date filed (Month, Day, 32. Regi trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2209 PM **Physician** 2017 Bradford Sarah Μ. 10 /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore HOZOH If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 18, 1928 (State or Foreign 5. Social Security Number 218-22-5484 Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 □XF 81 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No MD Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 Franklin Avenue 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Maryland Elementary/Secondary (0-12) College (1-4or 5+) Banking Operations NAtional Bank 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Bosson Emma Schnick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other tra once. 21152 Judy Brukiewa /daughter P.O. Box 412 Sparks MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 1X Buria Balto.Nat. Cemetery 6/14/10 Baltimore MD 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical D e to (or as a consequence of): Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Maryler of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) juare Drive Baltimore, MD 21237 N. malik ,mD 31. Date filed (Month, Day, Year) State

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at one.	To Be Completed by Funeral Director
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c 68760,	rtificate be executed ing physicien and as the burial-transit	Medical Examiner

Division of Vital Records, P.O. Box

	1 = For State Registrar	State of Marytain		tificate of Dea			ig. No.	IU	10011
	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h _ Day	Voor	3. Time of Death
n al	Lilv	Р.	Ва	rnes		June		Year .010	6:10A M
ai er	4a. Facility Name (If not institution, give s.			4b. City, Town, or Local	tion of Death		4c. Count	of Death	
	Golden Years Assi	sted Living		Raspebur	g		Ва	1tim	ore Co.
	5. Social Security Number 220-20-5354 6. Sex 1□	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, July 30	Year)	9. Birth Cou Lon	place (State or Foreign ntry) don, England
	Usual Residence of Decedent  10a. State 10b. County	100 Cib	. Town ask as						10d. Inside City Limits
_	71		r, Town or Loc	ation					1 Yes 2 No
ğ	Maryland Balti	more				Dunda			
Funeral Directo	10e. Street and Number 821 50th Street			10f. Zip Code	1222	1	og. Citizen of United		,
ner	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. W	Vas Decedent of Hispanie Yes, specify Cuban, Me	c Origin? (Spe	ecify Yes or No-		ce - Ameri	ican Indian,
Š	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ecify:	, tioan, oto.,	Specia		White
Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occupation	most of worki	ina	16b. Kind of E	usiness/lr	ndustry
를	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done during OO NOT use retired)	most or works	,,g	Drug	Stor	e
5	12 Years		Wa	itress					Service
Be (	17. Father's Name (First, Middle, Last)					(First, Middle, I		me)	
၀	William Cransto	ne			Elizab	eth Broo	kwell		
	19a. Informant's Name/Relationship (Typ			g Address (Street and No					
	Gerald W. Barnes (			50th Street					1222
	20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crem	Forest V.A.	6/15/ Cem-	2010	20c. Location		11s MD
	21. Signature of Funeral Service License		22.	Name and Address of F	acility				
	Vent &	lone-	Մu   7	da-Ruck Fun 922 Wise Av	eral H	ome of l	Dundall ) 2122	In	С.
,	23a / art1. Enter the disease, or course of shock, or heart failure. List is one	cations that caused the death							Approximate Interval Between
	Immediate Cause (Final disease or condition	P.	4	CARSION				. 4	Onset and Death
	resulting in death)	Due to (or as a consequ		() 1/=12/00	1,2	110	20112		
_	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequ	lence of):						
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Data to (or as a consequ	2811CO 01).						
Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
edical	<b>€</b> d.								
	IF FEMALE:	3c. If yes, outcome of pregna	nov						
Physician/N	in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)				ate of deli onth	very Day Year
ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	5 L	Other (specify)					
	Part II. Other significant conditions con	tributing to death but not resi	ulting in the un	derlying cause given in F	Part I.	23e. Did tol	acco use cor	tribute to	the cause of death?
Completed by						1 □ Ye	s 2 No	3 ☐ Pro	obably 4 Unknown
plet						24a. Was a		Were au	opsy findings available
E						autops perform	ned?	death?	ompletion of cause of 2□ No
0	25. Was case referred to medical			26.1	Place of Death	(Check only on		1 103	20110
10 B	examiner? 1 Yes 2 No	ospital: 1   Inpatient 2	ER/Outpatient	Other		me 5 Reside		her (Spec	ufy)
	27. Manner of Death 1 ဩNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe ho			
atic	2 Accident investigation			M 1 ☐ Yes	2 □No				
edical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Si City or Town		ber or Ru	ral Route Number,
<u>ت</u>	29a. Certifier 1/2 Certifying Phys	ician: To the best of my know	wledge, death	occurred at the time, da	te and place,	and due to the c	ause(s) and m	anner as	stated.
Medic	(Cleck only 2 Medical Examin	er: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my opinion	, death occurr	ed at the time, d	ate and place	, and due	to the cause(s)
<	29b. Signature and title of certifier			29c. License num			9d. Date sign		
	gu welow			700603	700	(	JUNE	10,2	010
	30. Name and address of person who cor		23a) (Type, F	Print)	, JI	ia n	00	RAJ	elo Timorejns
	31. Date filed (Month, Day, Year)	ERIA 910		INTO ELIZA	7 14 >	14- 1	(	1176	I I WEGINS
-	and the state of t	Tongrai a Gigila							

DHMH 17 Rev 1/2001

State Registrar

BV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 745 **Physician** DM. Linda Mi. Brown /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore tospita, quare osedale Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 11, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Social Security Number 1□M 2XF Months Days Hours Min. 237-60-4822 Carolina North 70 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Madical Examination must be notified at ury or other traumatic event, the Madical Examination. 1 □Yes 2 No Director Dunda1k Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21222 2505 McComas Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Factory Worker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Faw Loyd Lowery ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 2505 McComas Avenue Dundalk, Maryland Mr. Larry G. Brown (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify Entombment Holly Hill Mem. Gdns. 6/15/2010 Middle River, MD Funeral Service License 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter to shock, or heart isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illured the only one cause on each line. Immediate Cause (Final **Physician** Neumonia unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Empyema

Due to (or ds a consequence of): attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1⊡Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifles 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore Name

State Registrar

SROWN

MD

32. Registrar

Kottarathi'L

3 Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 201°0 Steven Anthony Barnecki, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Baltimore Co. Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 1, 1928 1 XM 2 F Months Days Hours Min. Pennsylvania Director 195-20-6273 82 Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Dunda1k ភ្នំ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8046 Mid Haven Road 21222 United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 🗌 No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3₺ Widowed 4 Divorced WWII White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Years Laborer Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Stebedka Steven Anthony Barnecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8046 Mid Haven Road Dundalk, Maryland Ms. Frances Shiloh (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp; 6/14/2010 Donation 5 Other (Specify) Towson, Maryland Signa e of Funeral Service Lig 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_ in the past 12 months? Month Year Day signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک Records, 1 Tyes 2 No 3 Probably Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural injury 5 Pending death. 1 Yes 2 No hin 24 hours after death the Funeral Director: Ampleted filled in by the f Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) 30. Name and address of berson cause of death (Item 23a) (Type, Print) 32. Regi State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ INE 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital kand\_11stown Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year Nov 17, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Min. Country Director 129-14-0467 85 New Usual Residence of Decedent or 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6825 Campfield Road 21207 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) healthcare should be filed with and Mental Hygien 7 is marked other the nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emma deBedts Clifford LeRoy Lyle 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Winehurst Road; Catonsville, Maryland 21228 Barbara Buck/daughter 1 and 2 s of Health item 27 i or other 20a. Method of Disposition 20p7 Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify of Funeral Service Lice 22. Name and Address of Facility State Anatomy Board; 655 West Baltimore Street Raltimore Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, beart failure. List only one cause on each line.

Immediate Cause Trinal disease or condition resulting in death)

Due to (or as a Interval Between Onset and Death SEPSIS Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): DEMENT physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 nding p IF FEMALE use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 5 Other (specify) Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? this certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ည 1 Inpatient 2 INER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 5 Pending death. 2 🗌 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 133 completed cause of death (Item 23a) (Type, Print) INDAUSTOWN 5401

Registrar

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Guy Physician/ Daniel Bavis Month Day 1 Year Ø9:36A Medical 4c. County of Death timore 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Joseph Medical Center Saint ocial Security Number 214-52-8824 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 6, 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 951 1 🕅 M 2 □ F Months Days Hours Min. Director 59 Yrs. MD Usual Residence of Decedent show 10b. County 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lutherville 28a-f 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21093 USA 114 Ardoon Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Service Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ျှ Mary George James Bavis traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 114 Ardoon Road, Lutherville, MD 21093 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any Injury or other trau once. Candace Gail Bavis / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 6/14/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 21. Signature of Funeral Service Lige 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Porota Marshall Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARDIAC ARREST disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARRHYTHMIA Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of that the death certificate be executed PULMONARY HYPERTENSION physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending phase the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a d be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe Yes 2 No 2 🗷 No 1 Tes Physician 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 **N**O ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural (Month, Day, Year) 5  $\square$  Pending hin 24 hours after death.

the Funeral Director: As Tipleted filled in by the fu 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physícian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner: To the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29Ь. **S**Ignature 29d. Date signed (Month, Day, Year) 3 10 DE9931 vho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person OSLER DRIVE TOWSON, MARYLAND 21204 601 ORENTZ M. D. 32. Regis rar's Signature State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fb g904 6-15-10 vt. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deat **Physician** 18:00 200 Sacility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Year) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Min Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It w Medical Examinar must be notified at 1XYes 2 No KaltiMore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**1** No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 44 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lor tilda unknown ပ nformant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, life Baylor Street Baltimore, Maryland 20b. Place of Disposition (Name of New ry Carting drag place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ratimore, Maryland Algnature of Funeral Service 22. Name and Address of Facility . Treene Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to meeting to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No cate nas been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate CICLO83 1 ☐ Yes 💖 No 25. Was case referred to medical examiner? 1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 **200**0 pital: 1 Doppatient 2 ER/Outpatient 3 DOA

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
Injury
28c. Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death
1 Death
2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after deaun.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier State Registrar

DHMH 17 Rev 1/2001

	A	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  mend 10b-c, per AB 6904 6/15/10 Th State of Maryland, Department of Health and Mental Hygiene Amend 19a, per AB g904 Cortificate of Death
Physici /Medic	an al	1. Decedent's Name (First, Middle, Last)  Chuk wuma, Chike - D  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death
Examir Funeral Director		THEME 4940 Factor are  Social Security Number INFANT  The Month Day Foreign Foreign And Social Security Number INFANT  Buttimore  Buttimore  Buttimore  Buttimore  Buttimore  Buttimore  Cyty  Social Security Number Infant  Social Security Number INFANT  The Month Day Foreign And
70	Director	Usual Residence of Decedent  10a. State
72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Ever her must be notified at	Funeral	/89 Linhead       Ct.       USA         11. Marital Status       12. Was Decedent Ever in U.S. Armed Forces?       13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)       14. Race - American Indian, Black, White, etc.         1 ☑ Never Married       2 ☑ Married       1 ☐ Yes 2 ☑ Nolif Yes, Give       1 ☐ Yes 2 ☑ No Specify:       Specify: Alack
filed within 72 hours aft Hygiene. other than "natural", or ent, the manal matural or	Completed by	Solution   Specify only highest grade completed   Solution   Specify only highest grade completed   Solution   Specify only highest grade completed   Solution   So
should be file and Mental Hy marked oth	To Be C	17. Father's Name (First, Middle, Last)  Chike Collins, Ogbueff  18. Mother's Name (First, Middle, Maiden Surname)  Christiana, Murray  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2006)
o ë c' = b		Mother Christina Murray 189 Lionhood Ct. Rosedou, MD 2033  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation Stother (Specify) in State
		21. Signature of Funeral & grice-Licensee Baltimore Street  22 State Anatomy Board; 655 West Baltimore Street  Baltimore, Maryland 21201  23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Ca Efinal
Physician  Titicate be executed  By a physician and as the burial-transit  The physician are the burial-transit  The physician are the phy	ical Examiner	Immediate Calculation disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  e. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):
attendir for use	Physician/Medical	IF FEMALE:     23c. If yes, outcome of pregnancy       23b. Was decedent pregnant in the past 12 months?     1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy     3 ☐ Ectopic pregnancy     Month Day Year       1 ☐ Yes 2 ☐ No 9 ☐ Unknown     9 ☐ Unknown
requires that t	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknow 24a. Was an 24b. Were autopsy findings available.
vician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Be Compl	25. Was case referred to medical examiner?
or Attending Physiater death. Director: After this in by the funeral di	Certification: To	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 1 Dyes 2 No  28c. Injury at Work? M 1 Dyes 2 No  28d. Describe how injury occurred
the Hospital ithin 24 hours a the Funeral ompletely filled	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier.
10 Wit 10 CO		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  W. R. Ibinana M.D. 71774
S Regir	lele trar	Cynthir H. Amani, 4940 Eastern MV. Baltimore, MD 2124  31. Date filed (Month, Day, Year)  32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ aMPBELL 5:19 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland BALTIMORP Medical Center N/A 5. Social Security Number 8. Date of Birth (Month Day, Year) 77 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 | M 2 | F Hours Director Alabama 32 419-23-8198 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Harford Edgewood 10e. Street and Number 10g. Citizen of What Country? Funeral 706 Court Square Drive 21040 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Chemist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ည Thomas T. Campbell Linda Gail McElrov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is and 2 s Health Thomas T. Campbell/ Father 450 County Road 589, Town Creek, Alabama 35672 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of to 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or Metro Crematory, Inc. 6/11/2010 Baltimore, Maryland Signature of Funeral Service License Ananda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ FULMINANT Mepatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HENOL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury CERTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of) physician ar s the burial-tr Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ DEPRESSION 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law rewithin 24 hours after death. page 2 s autopsy certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗌 No Other: ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 ☐ Natural 2 ☐ Accident 3 ☑ Suicide 5 Pending within 24 hours after death.

To the Funeral Director: After any or the further of the further or the further o 1 🗌 Yes 6/09/2010 12:00 PM Investigation 6 Could not be suicide AHEMPE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined , MaryLAND DGEW000 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 72298C M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore, Marylano 21201 rennie AW 31. Date filed (Month, Day strar's Signature State Registrar

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alvin Alexander Cockrill 2010 June 1:18a <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2B Nicholson Drive Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Und Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Virginia Months April 21 226-60-8727 Director 63 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2B Nicholson Drive 21122 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Sales Stee1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alvin Cockri11 Mary Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kari Cockrill, Daughter 2B Nicholson Drive, Pasadena, Maryland 21122 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/14/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending death. 2 No ☐ Accident ☐ Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined filled 24 hours a Medical 29a. Certifier To the Hosp within 24 ho To the Fune completed fi 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certific 29d. Date signed (Month, Day, Year) 00574136 00-14-2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 s. Greene St. Baltimeremourol. p. mannul 31. Date filed (Month, Day, State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 5:30 AM Robert L. Calzetta June 15, 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arden Courts Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 2 F Months Hours (Month, Day, Yes Aug 10, Year) 89 Director 156-05-5807 New Jersey Aug 1920 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Baltimore Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6729 Glenkirk Road 21239 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 0 Black, White, etc. þ 1 Never Married 2 Married 1 Ka Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. "natural", 3 Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Luigi Calzetta Maria Biagi ge 1 and 2 should b it of Health and Mer If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert K. Calzetta /Son 6729 Glenkirk Road Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Jun 16 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Complications 1005 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician detached for use as the human Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2 ☐ No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Yes ပု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 Jest, (RNP June 15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MND

TOUSON

N. Charles

32. Registrar's Signature

6701

JUN 1520

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 JUNE 2:40 TINA MARIE COSNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1705 C Crimson Tree Way Edgewood If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year, 29 1 🗆 M 2 🔀 F Connecticut Director 049-66-2527 48 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 C Crimson Tree Way 21040 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than '
traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 12 Home Health Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဥ Grover William Katan Justina Rosemary Defarari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1705 C Crimson Tree Way, Edgewood, MD 21040 Allan D. Cosner / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland Hillcrest Memorial Park 6-16-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. othleen Santivasci 1317 Cokesbury Road, Abingdon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician sea disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? signed by the atte d be detached for Pregnant at time of death Month Day Year 2 No Yes 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕽 Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 2847 JUNE 14, 2010 PHYSTCZAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAON GOONTA BEC AZR MD 21014 SUATP 60 2 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

10-04425 Gurinderjit Dhillon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

•		1- For State Certi	ficate of Death	Reg	. No.	10022
Physici	an/	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death 2347 hrs
Medical Exami	ner	Gurinderjit Singh Dhillon	Ab City Tayy and position of Doot	June 10, 20	10 4c. County of Death	2347 HIS
		Facility Name (if not institution, give street and number)     Harbor Hospital	4b. City, Town, or Location of Deat Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24Hr  Months Days Hours Mir	_	(MM/DD/YYYY) 9. Birth Foreign	1 1 1
Director	ł	<del>680</del> -34-3849 1₺ м 2□F	48 Yrs. Months Days Hours Min	April 1		ntry) India
ě	- [	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location		1	Od. Inside City Limits
ow any						1 Yes 2 No
vfaryland 28a-f show d at once.	햟	Maryland   Anne Arundel   10e. Street and Number	Linthicum Heights Tiof Zip Code	100	. Citizen of What Countr	**
0036 within 72 hours after death with the Maryland yiene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	9	233 North Hammonds Ferry Road	21090		India	,
with the same second		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S		14. Race - America	n Indian, Black,
death or item nust t	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify:Asian	
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	<ol> <li>Decedent's Usual Dccupation (Give kind of during most of working life. DO NOT use ret</li> </ol>		6b. Kind of Business/Inc	dustry
36 hin 72 e. than '	ompleted	12	Cab Driver		Self Empl	havo
5-00 led wit tygien other	Con	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		oyea
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Gurcharan Singh	Pritan			
ID 21 should and Mc 7 is ma	유	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or			21050
e, MD 1 and 2 sho Health and item 27 is	- 1	Jasbir Kaur, Wife	233 North Hammonds Feace of Disposition (Name of cemetery		Linthicum He 20c. Location - City or To	
F 2 4 5 0		1 Burial 2 X Cremation 3 Removal from State	ematory or other place)		•	·
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to	-		ro Crematory Inc. 06/		Baltimore,	Maryland_
Ba Perm Depa Impe	ı	21. Signature of Funeral Service Liegnsee Thomas Grego:	r MacNabb Funeral Ho 301 Frederick Road	ome, P.A. I Catonsv	ille Marvl	and 21228
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.				Approximate Interval Between Onset and
M i l Examiner		Immediate Cause (Final disease a. Complications of chronic	alcoholism			Death
LAMITICI		or condition resulting in death)  Due to (or as a consequence of):				
	ᡖ	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):				
	Examiner	Course Enter Underlying Cause (Disease or injury that initiated				
ted Insit	Ξ	events resulting in death) Last  Due to (or as a consequence of):  d.				
760, icate be executed physician and the burial - transit	g	T LINDENDED X AMENDED		_		
60, ate be shysici ne buri	Medical	# 5 per F H , G IF FEMALE: 23c. If yes, outcome of pregna	904,6/24/2010,WS		23d. Date of delivery	
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	ancy	Month Da	y Year
Box 687  he death certific  the attending I  hed for use as the	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
2 = 20		Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
i, P.O. ires that the signed by	d by			1 Yes	2 No 3 Probal	bly 4 Unknown
cords aw requi as been 2 should	ee			24a. Was an autopsy		psy findings available npletion of cause of
of Vital Recoling Physician: The law After this certificate has luneral director, page 2 si	Completed			perform 1 Yes 2	ed? death?	2 No
an: T ertificator, p	Be	25. Was case referred to medical	26.Place of Death (Check			
Vital hysician:		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Y E			esidence 6 Other:	
n of \ding Phy.  After tl funeral		1 Month, Day, Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
ivisior	lăi	2 Accident Investigation	1 Yes 2 No	OOK Laasties (Che	eet and Number or Rura	I Bouto Number City
그 무용 두 드	Certification:	Suicide Could not be determined (Specify)	ne, farm, street, factory, office building, etc.	or Town, Sta		Route Number, City
lospit 4 hour uners		29a. Certifier	death occurred at the time, date and place, and	due to the cause(	s) and manner as stated	
Di To the Hospital within 24 hours a To the Funeral I	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my opinion, death occurred	at the time, date an	d place, and due to the	cause(s)
8 7 8 7	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	n, Day, Year)
		Calmer H	O.C.M.E.		June 11, 2010	
101		30. Name and address of person who completed cause of death (Mem 2)				
,		Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	1201		
St Regis	ate trar	31. Date filed (Month, Day, Year)  32. 5 Egistrar's Signature 33. 5 Egistrar's Signature	1. park			
- I (egis		JUNE I LUIU I FRANCE P			UU WIL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>10:4</u>0<sup>a</sup> м Month Physician/ DOROTHY DEWITT June 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖵 F 92 Months Days Hours Min. (Month, Day, Year) Country) 579-09-1139 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 🗌 Yes 2 🔯 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14635 Bauer Drive #213 20853 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Missionary</u> Religious Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Randolph Baugh Lillian Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry DeWitt, son 4116 Mt. Olney Lane, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/12/2010 Beltsville, MD 21. Signifury of Funeral Se . Li ense 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) MYOCARDIAL INFARCTION Medical Due to (or as a consequence of) Examiner VENTRICUL RIGHT Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) ed by the a detached f g 🗌 Unknown P.O. signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tyes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of cartifier 29c. License number 2010

State Registrar

DHMH 17 Rev 7/2009

15525 Shady Grove Rd. Ste. 201; Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Hsing-Teh Wang,

10-04438 Frances Kay Dell	ling	Please Type or Print in Black Indelible Ink. Ensure All Copie er State of Maryland / Department of Health and Mental H		2010 2010	18524
		1- For State Certificate of Death Registrar		g. No.	
Physicia Medical Examir	n/ 1er	1. Decedent's Name (First, Middle,Last)  Frances Kay Dellinger	2. Date of Death Month June 11, 20	Day Year	3. Time of Death 1436 hrs
		4a. Facility Name (if not institution, give street and number)  2913 Overland Avenue  4b. City, Town, or Location of Death Baltimore		4c. County of Death	1
Funeral Director		5. Social Security Number 517-60-9320 1 M 2 F 66 unk Yrs.   1f Under 1 Year   1f Under 24Hrs   1f Under 24Hrs   1f Under 1 Year   1f Under 24Hrs   1f Under 24Hrs   1f Under 1 Year   1f Under 24Hrs   1f Under 24		1944 Foreig	thplace (State or in D.C. untry) unk
nd show any sce.	_	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tified at once.	Director	10e. Street and Number 10f. Zip Code 2913 Overland Avenue 21214		g. Citizen of What Cou	ntry?
	/ Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 11. Was Decedent Ever in U.S.  12. Was Decedent Ever in U.S.  Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-		can Indian, Black,
136 thin 72 hours a te. than "natural	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Homemaker  Social Worker	red)	16b. Kind of Business/ Own Home	ndustry unk
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last) 18.Mother's Name	First, Middle, M	aiden Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	To Be	Loy Edger Dellinger  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F			unk Zin Codo)
Jre, MD 21215-0036 ss 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than her traumatic event, the Medica		Bonnie Yanks Raindrop/ 15442 Magnolia Dr:  20a. Method of Disposition (Name of cemetery,			17349 n. PA
MOFE ages 1 ent of H nt: If i		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Chesapeake Crem. 06	14 10	Beltsvil	le MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1	21 Signature of Funeral Service Licensee  MONUS  22. Name and Address of Facility AFT  8717 Green Pasti	A/Steph	en D. Lo	nrmann,P <sub>A</sub>
Physician /Megi al		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o failure. List only one cause on each line.			Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wound of Chest  Due to (or as a consequence of):			Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execu an and	[필	d.			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physicial physician by the funeral director, page 2 should be detached for use as the buring the buring and the purity filled in by the funeral director, page 2 should be detached for use as the buring the purity of th	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (Specify) 9  Unknown	incy	23d. Date of delivery Month	day Year
P.O. I es that the signed by the detache	ক	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
Division of Vital Records, P Ialor Attending Physician: The law requires is after death.  al Director: After this certificate has been sign led in by the fineral director, page 2 should be to	Completed		24a. Was ar autopsy perform 1 Yes 2	prior to death?	topsy findings available ompletion of cause of s 2 No
ital Recision: The secrificate irector, page	å	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		esidence 6 🗸 Other	Scene
on of Vital Reconding Physician: The th.  r. After this certificate to funeral director, page	ion: To	27. Manner of Death  1 Natural 5 Pending FOUND: Day, Year)  28b. Time of Injury 28c. Injury at Work?  FOUND: FOUND: 1 Yes 2 ✓ No		w injury occurred	. decine
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Tiotilicide	or Town, Sta	reet and Number or Ru ite) Avenue, Baltimore,	
the Hos in 24 h the Fun pletely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To the within To the comple	Medical	29b. Signature and title of certifier   29c. License number  O.C.M.E.		29d. Date signed (Mo)	
	-	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	L	,	
Sta Registr	te	31. Date filed (Month, Day Year)  32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year DOLAN FRANCES 06:55AM JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHN'S HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 216-12-3309 91 Months Days Hours Min. (Month, Day, Yo **Director** 1918 Sept Usual Residence of Decedent or 28a-f show s notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10 Helena Avenue 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert F. Gross Lenora Slattery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Skupas /daughter 10 Helena Ave. Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hoffigh Hill Cemetery 6/15/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) . Signal re of Funeral Service Licens 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Thous Immediate Cause (Final Physician/ a VENTRICULAR THCHYCARDIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 week HYPOXALEMIA Sequentially list conditions, Physician/Medical Examine If any leading to himself cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 3 month CHRONIC DIARTEA Due to (or as a consequence of) resulting in death) Last 4months COLON CANCER Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 🛂 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mannet of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LORA BANKOVA, MD JUNE 12, 2010 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANKOVA, M.D. 4940 EASTERN AVENUE BALTIMORE MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 2 Day 2010 Ellis 1 A David John **Physician** 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Caroline Nursing Home 8. Date of Birth (Month, Day, Yea, 2/23/1927 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1A M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 83 Marvland 217-24-2524 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examination and individual at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 □ No Director N/A Marvland Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3717 Delverne Road 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWIT White Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) 5+ Elementary/Secondary (0-12) Police Department Criminologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis Marie James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3717 Delverne Road, Baltimore, Maryland 21218 Elizabeth T. Ellis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 6/15/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundant Street Lines MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death year and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 TYes 2 □ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morth Co 10:31 M Catherine Early Medical Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner alislau concido Ce at the If Under 1 Year If Under 24 Hrs. B Date of Birth
(Month Pay, Year) 41 Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days 1 □ M 2 🖾 F Months Hours Min. MaryTand 69 214-42-9352 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21851 USA 206 Linden Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: white If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) antique dealer estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willis Leon Messick Eugenia Dashiell Anderson 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis E.M. Early Jr/spouse 206 Linden Avenue; Pocomoke, Maryland 21851 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Signatur of Funeral San ( State Anatomy Board; 655 W. Baltimore Street 221 Maryland 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter engenying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths? 3 Ectopic pregnancy Month 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Pother (Specify) HOSPICA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifie 29c. License number D0058410

State Registrar BOX

173) SALISBUMP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARY

GHU AM WA

31. Date filed (Month, Day, Year)

P.6

32. Regir trar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Fritze (seurge 4:11 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimore Bayview Medical Center Johns Hopkins If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months (Month, Day, Year) March 10, 1936 Country)
Maryland Hours Director 212-32-8541 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 Ambler Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 □XYes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Auto Parts Manager Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bessie Marjorie Hentsch Carl Furman Fritze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Laura Fritze 2501 Ambler Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot June Date 5, cemetery, crematory or other place)
Bayview Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 21. Signature of Funeral Service Licensee <sup>22 Name and Address of Facility</sup> Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Li Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ heart Congestive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LUTUNALY Sequentially list conditions, Examine Directo for as a consecuence of frank leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No certificate **Division of Vital** director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 🗌 No Accident Investigation 1 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number RES-000 Medical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 940 Avenue, Baltimore, MD, 2122 Eastern ug lese istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 20TO 7:00PM Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE COURTLAND GARDENS PIKESVILLE Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 02/2671921 Min 220-09-6849 89 Yrs. MD **Director** Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE MD BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6524 COPPERFIELD ROAD 21209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Arrored Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the **PHARMACIST** PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FREEMAN SADIE GOTTLIEB BERNARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 6524 COPPERFIELD ROAD, BALTIMORE, MD 21209 RETA FREEMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State FORBAND CEMETERY 06/14/2010 ROSEDALE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e on each line. 23a. Part 1. Enter the disease, or complication Interval Between Onset and Death shock, or heart failure. List only one cally Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exami attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Tes of Vital 25. Was case referred to medical or Attending Physician; funeral director, Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no 27000 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ JUNE 8 Esther 7:55pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min MARYLAND Director 218-16-9810 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No CHANCE MD. SUMMERSET 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21816 USA 10680 TODDVILLE RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PERSONNEL STATE OF MARYLAND -12--0permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ORA BECKETT GEORGE BECKETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6813 FAIMLAWN AVE. BALTIMORE, MARYLAND 21215 PHYLLIS SCOTT(DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 X Burial 2 Cremetion 3 ☐ Removal from State SPRINGHILL MEM. GARDEN 6-16-2010 HEBRON, MARYLAND 4 Donation 5 Qther (Specify) D. HIBNI'S Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. MANTANOL 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeri ke Cause (Final disease or condition Atheroscientic Cardiovascular Disease Pnysician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate 1 🗌 Yes 2 🖼 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A 1 Tes Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. ₃ □ only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskampahrem.D D0057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. RAYAPAKSE, M.D. 2835 Smith Av. S-735 -Baltimore, MD. 21209 N.S. Rayapakse, M.D

State

Registrar JUN 152

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Gregory		1- For State	tate of Maryla		artment o <i>rtificate o</i> :		d Mental F		201 eg. No.	0	18532		
Physicia	n/	1. Decedent's Name (First, Midd						2. Date of Dea Month	th Day Year		Time of Death		
Medical Examir	ner	William  4a. Facility Name (if not instituti	Ramon		gory	4b. City, Town, or	Location of Deal	June 12, 2	2010 4c. County o	f Death	1120 1115		
		535 Bowlin Terr				Upper Marl	boro		Prince G		i		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea Months Day		n		Poreign West Va.			
Director		235-08-8846 Usual Residence of Decedent	1 2 F	46	Yrs	3.		Nov.6,	1963	Count	in color va.		
any	ľ	10a. State 10b. County		10c. City	, Town or Locat	ion		·	•	i i	0d. Inside City Limits		
land f show	គ្ន	Md Prin	ce Georg	es Upp	er 1	Marlbor	0				1 Yes 2xxNo		
e Mary or 28a-	Director	10e. Street and Number 535 Bolin T				10f. Zip Code		1	0g, Citizen of Wha	at Country	ņ		
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.		11. Marital Status		cedent Ever in U	I.S. 13. Wa	20774 as Decedent of His	spanic Origin? ( \$	Specify Yes or No	USA 14. Race	America	n Indian, Black,		
death or item	Funeral	1 Never Married 2 N	Armed Fo	orces?	lf Y	es, specify Cubar	n, Mexican, Puert	o Rican, etc.)	White	etc.			
s after ral", o	ਨ	3 Widowed 4 Di  15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates:		1 Deceder	Yes 2 X No		wat dans	Specify:B				
2 hour	Completed	Elementary/Secondary (0-12)				ost of working life					ustry		
036 tithin 7 ene. or than	힐	12			Care	Taker			Cemet	ery			
		17. Father's Name (First, Middle William Ru		arr	<del>-</del>		18.Mother's Nam Joyce		Maiden Surname)				
212 ould be Menta marke	o Be	19a. Informant's Name/Relation	ship (Type, Print)	mostic	19b. Mailin	g Address (Stree		Grego Rural Route Num	nber, City or Town	, State, Z	ip Code)		
MD d 2 shc lith and n 27 is		Phillip Mitc	hell- Pa	rtner	535	Bolin T	errace	Upper	Marlbo	ro,N	1d.20774		
of Hear It		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal fr	om State	crematory or ot			Date	20c. Location -	•			
ti Pag	-	4 Donation 5 Other S		Ple	easant	Valley	Mem 6	/19/10	Annand	ale,	Va. Clington		
Ba perm Depa Impo injur			Balu Fr		Ch	inn Fun	eral S	ervice	2605 S.; Arl.Va	Shir	Lington		
Physician	T	23a. Part I. Enter the disease, o failure. List only one cause		aused the death	. Do not enter t	ne mode of dying,	such as cardiac	or respiratory arr	est, shock, or hea	rt .	Approximate Interval Between Onset and		
/Medical Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)	-			iovascular Dis	sease			-	Death		
	-	Sequentially list conditions,	b	consequence o	or).								
	if any, leading to immediate Due to (or as a consequence of):												
gi, d	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
50, tte be executed sysician and burial - transit	edical Examiner	UNPENDED	d.  X AMENDED										
60, ate be e hysicia e burial	- 1	IF FEMALE:	1	PII per		5 7/2/10	) TT		23d. Date of c	delivery			
ox 6876 eath certificate attending phy for use as the t	any	23b. Was decedent pregnant in t past 12 months?	the 1 Live b	_	2 Fe	tal death 3	Ectopic pregn	ancy	Month	Day	y Year		
30x death o e atten I for us	Physician/N	1 Yes 2 No 9 Un	oknown 9 Unkno		eath 5 Ot	her (Specify)							
Division of Vital Records, P.O. Box 6876 is lor Attending Physician: The law requires that the death certificat rs after death.  at Director: After this certificate has been signed by the attending physel in by the funeral director, page 2 should be detached for use as the		Part II. Other significant condi	tions contributing to	o death but not r	esulting in the u	ınderlying cause ç	given in Part I.		bacco use contrib	_			
S, P juires th	ed by	Cocaine use						1 Yes			oly 4 Unknown		
Vital Records, ysician: The law requii this certificate has been in the certificate ha	Completed							autop	sy pr		npletion of cause of		
Rec: The ifficate		25. Was case referred to medical	-1			26 Plane	of Death (Check	1 ✓ Yes		<b>✓</b> Yes	2 No		
/ital ysician his cert	o Be	examiner?	Ulassital:	Inpatient 2	ER/Outpatient		Other		Residence 6	Other: S	cene		
of ing Phy	-t	27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. Time of I		ry at Work?	28d. Describe	how injury occurre	đ			
Sion Vittendi death. cctor:	  gi		estigation				Yes 2 No	2001			D 1 N 63		
Divis	Certification:		ald not be ermined (Specify)		ome, farm, stree	et, factory, office b	bullaing, etc.	or Town, S		or Rurai	Route Number, City		
hou hou		29a. Certifier 1 Certifying P	Physician: To the bes	st of my knowled	lge, death occur	red at the time, da	ate and place, an	d due to the caus	se(s) and manner a	as stated.	cause(s)		
To the withing To the comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29g. Signature and title of certifier  29d. Date signed (Mont.)											
	=	Marin - Dr	ne Ja. 10			O.C.I			June 13, 20				
	-	30. Name and address of person		•	•				<u> </u>				
		Margarita Korell MD.	Assistant Med	dical Examir		enn Street, B	altimore, MD	21201					
Sta Registi	rar	31. Date filed (Month, Day, Year)	010 Jens	un A.	park	W.							

Physician/ Medical Examiner

Physician/

Medical

10a. State

2203

Director

Funeral

Completed by

Be

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Examiner

**Funeral** 

**Director** 

or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or from many injury or other traumating.

J physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending p within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

P.O. Box 68760

Records,

Division of Vital

0	that initiated events	C									
Еха	resulting in death) Last	Due to (or as a consequence	uence of):								
lica		d									
e e											
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown		23d. Date of delivery Month Day Year								
۵	Part II. Other significant conditions of	ontributing to death but not res	g cause given in Part I.	art I. 23e. Did tobacco use contribute to the cause of death?							
Completed		24a. Was an autopsy performed?									
Be (	25. Was case referred to medical			26. Place of Death (Che	ck only one)	1-1	500.00				
0 0	examiner? 1 ☐ Yes 2 ☒No	Hospital:	ER/Outpatient 3	lome 5 Residence	6 Other (Spec	ify) of C					
ertificate:	27. Manner of Death  1 Autural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred					
O	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	OGI. O:		/				0 1/ 1				

State Registrar ame and address of perso

who completed cause of death (Item 23a) (1) pe, Print)

Gross, Louis 07/25/15 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07/25/	15	-	State		State of	Maryla	-	artment of F		/iental Hy	- /	PAL	Ω	185	34
Registrar  1. Decedent's Name (First, Middle, Last)							Cer	rtificate of Death		Reg. 2. Date of Death		No. U I U		3. Time of D	)eath
	sicia							Gross		Month	Da	Day Year			1.4
	/ledic	aı :	Louis Allen  4a. Facility Name (if not institution, give street and number)						Location of Death	L 06		. County of		L9:23	a
1			4022 Barr	ington	Road			Bal	timore						
	eral		5. Social Security Numb	er 6. Se	x		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B			9. Birthpl Count	lace (State or I	Foreign
Dire	ctor		<del>217-09-58</del>	41	<b>X</b> M 2□F	94	Yrs.	World Suy o	Tiodio Iviiii		25	15		MD_	
pu <b>woy</b>	at	- 1	Usual Residence of Dec 10a. State 10	b. County		10c. C	City, Town or Lo	cation		_			10	Od. Inside City	Limits
laryla 3a-f s	ified	Director	MD	NA			Balti	more			1-₹				2 🗆 No
the M or 28	e not		10e. Street and Number			L		10f. Zip Code			10g. Ci	itizen of Wh	nat Count	try?	
with s 23a	nst b	Funeral	4022 Barr	ingtor	Road			21	207			U.	S.A.	•	
death	er m	틦	11. Marital Status	111900	12. Was Deced		J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No	-	14. Race	- America White, e		
36 after of ", or	tamir	þ	1 Never Married		1 Yes If Yes, Give	2 🗌 No		I ☐ Yes 2 <b>X</b> ☐ No		,		Specify:		ack	
Ours attural	E E	Completed	3 ▼ Widowed 4 □ Divorced Year  15. Decedent's Education					dent's Usual Occupation			16b. Kind of Business Industr				
21215-0036 within 72 hours after giene. her than "natural", o	Medic	힏	(Specify only highest grade completed)				(Give	ing	16b. F	(ind of Bus	iness ind	lustry			
212 within giene.	the last	اق	Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na				1	ngeshor			MD Drydock				
iled v Iled v	vent,	8	17. Father's Name (First						18. Mother's Nam	ne (First, Middle	e, Maiden	Surname)			
Maryland 2 should be filed th and Mental Hy 27 is marked oth	itic e	잍	Robert E.	Gross	š				Rosetta	Sparı	cow				
land Should and I	anus		19a. Informant's Name	Relationship (Ty	pe, Print)			ng Address (Street			-				
nd 2 sealth m 27	Ter tr		Carolyn C		-Daugl			Sagra	Road, B	altimo	_		212		
Ore le 1 a t of H	p of		20a. Method of Disposit		Removal from 5		<ul> <li>Place of Dispo cemetery, crer</li> </ul>	sition (Name of natory or other plac	ce)	Date	20c. L	ocation - C	ity or To	wn, State	
timen: trmen: tant:	jury		4 Donation 5	Other (Specify	)			Forest		18/10	Ow	ings	Mi	lls, N	Md
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any in	-	21. Signature of Funeral Service Licenses  22. Name and Address of Facility  March F/H West  4300 Wabash Ave, Baltimore, Md 21215												
		$\neg$	23a. Part 1. Enter the c	lisease, or comp	olications that ca	aused the de								Approximate	
Physic	ian/	ļ	shock, or heart fail		R h		Haral	Athon	Lo				,	Interval Between nort an LDe	eath
Med	lical		disease or condition resulting in death)  Due to (or as a consequence of):												
Exam			Sequentially list conditions, b. Chronic Non-Lealing Multiple Infector would 1/1/07											5	
	-	ine	if any, leading to immediate  Due to (or as a consequence of):										1 4		
760 rate be executed physician and	trans	хап	Cause (Disease or iinju that initiated events	ry	c. Due to 6	or as a conse	augus of:	( M 2	hem	v te	the		- 1	11/00	
be exe	ourial	ial E	resulting in death) Last			~ L /		bullow	2			11107			7
760 cate b physic		edical		10.	d	3-0	41	20,00						11101	
ox 687 sath certifica attending p	use as		IF FEMALE: 23b, Was decedent pre-	gnant	23c. If yes, outo		1		23d. Date of delivery						
Box 68 death certific he attending	d for	icia	in the past 12 mon 1 ☐ Yes 2 ☐ N	ths?	4 Pregn		☐ Ectopic pregnand ☐ Other (specify)			Month Day Year			ar		
ords, P.O. Be requires that the de been signed by the	ache	'n	9 Unknown		9 🗆 Unkn	g ∐ Unknown									
P.C	se det	by	Part II. Other significar	nt conditions co	entributing to de	ath but not r	esulting in the u	ınderlying cause giv	tobacco use contribute to the cause of death?						
ds, quire: en siç	apple		Imo	15 lb-			Yes 2 No 3 Probably 4 Unknown								
Records, P.O.  The law requires that the cate has been signed by the cate has been sig	2 sho	Completed	Can	tract	m					24a. Wa aut	s an opsy	pri	ior to cor	osy findings av npletion of cau	railable use of
Re la The la ate h	page	Son	Ch	an (c	201		formed?								
Vital Reco sician: The law a s certificate has b	ctor	Be	25. Was case referred to medical examiner?												
f Vi	al di	욘	1  Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
John Filmg F	funera	Certificate:	27. Manner of Death Natural 5	Pending	_ i	h, Day, Year)	28b. Time of injury	work	y at ⟨? Yes 2 □ No	28d. Describe	how inju	ry occurred	!		
SiOI otten deatl ctor.	y the	ţį	2 Accident Investigation 3 Suicide 6 Could not be 4 Validide 6 Could not be 28e. Place of Injury - At home, f						Street and Number or Rural Route Number,						
Division of Vital tal or Attending Physician: s after death.	d in b		4 U Homicide	determined		g, etc. (Spec		City or Town, State)				',			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	ed fille	Medical						occured at the time							max -t-1:
ы 4 д н Н 2 д д н	plete	Mec	(Check   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												ner stated.
N ###	СОП		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
			Ina Opeene-Up DNRCKNP R13/119 6/11/2010												
SY	<b>V</b>		30. Name and address	of person who c	mpleted cause	e of death (Ite	em 23a) (Type, F	Print)				_			
	01		705 D, c 31. Date filed (Month, D		32. Re	_	TE G	unthic	vn.n	JD 3	2100	10			
Re	Stat gistra		· · · · · · · · · · · · · · · · · · ·	UN 152		iou aire.oigi		had I							
			2	AIL TO		aller I	19.19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 142 M arris 2010 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death timore iversity If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Min. Hours 217-52-9421 60 Director 19-1950 SOUTH CAROLINA Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3412 CATON AVE items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married "natural", or þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) -12-College (1-4 or 5+) BAKER FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHAN HARRIS MARY WORSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WANDA HARRIS (WIFE) 3412 CATON AVE. BALTIMORE, MARYLAND 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛚 Burial 3 Removal from State ARBUTUS MEMORIAL PARK 6-19-2010 BALTIMORE, MARYLAND 4 Donat n 5 🗆 Other (Specify) Signature Service Licent TOWATHAN HIBNER 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Fig. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or, or heart failure. List only one cause on each line. Approximate shock, or heart failu Immediate Cause (Final dise e or condition Interval Between Onset and Death Physician Kidney Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical r Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) detached for in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 this certificate 2 1 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After . 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death 2 Accident
3 Suicide
4 Homicide Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) i-cura Diegel MAN 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) niverside 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 7, 8:35 A<sup>M</sup> 2010 Oliver Wendell Hedges, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Wyoming Yrs. Jan. 8, 76 Director 520-38-7436 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shoy r then "natural", or Items 23e or 28a-f show the Medical Examinar must be notified at 1 Yes 2X No Vienna Fairfax Virginia Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22182 USA 1219 Carpers Farm Way 12. Was Decedent Ever in U.S. Armed Forces? 1/25/56 1 \$ Yes 2 □ No If Yes, Give 10/1/85 Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Computer College (1-4or 5+) 5+ and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) Sciences Director, Marketing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be find and Mental F Eunice Searle Oliver Wendell Hedges, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other traum once. 2700 S. Grant Street, Arlington, Virginia 22202 Christine Baron, Daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Arlington National Cemetery 1 ■ Burial 2 Cremation 3 Removal from State September 4 ☐ Donation 5 ☐ Other (Specify) 23, 2010 Arlington, Virginia 21. Signature of Fun al Service Licensee 22. Name and Address of Facility
Funeral Choices of Chantilly
14522L Lee Road, Chantilly, Virginia 20151 23a. Part 1. Enter the discussions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 TUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the autopsy performed 1 ☐ Yes 2 🛣 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 15 2010 MN June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St., Baltimore, MD 21287 MD 55, Kei 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar	•			ental Hyg	giene	Y	44570		
			Registrar  1. Decedent's Name (First, Middle, Las	st)	Cer	rtificate of Dea		2. Date of Dea	Reg. No.	3. Time of Deat	th		
	Physicia		Violet Ro		is			Month June	Dav	Year 010 6:15 A	М		
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or Loc	cation of Death		4c. County o	<u> </u>			
			Manor Care Silv				r Spring			tgomery			
	Funeral		5. Social Security Number 6. So	M 2 VF	last birthday) Yrs.		ours Min.	<ol> <li>Date of Birt (Month, Day</li> </ol>	, Year)	9. Birthplace (State or Fore Country) Virginia	eign		
	Director		217-22-2378 Usual Residence of Decedent	86				Jan. 1	3,1924	VIIginia			
	land shov d at	tor	10a. State 10b. County	10d. Inside City Lin									
	Mary 28a-1 otifie	irec		George's		sville				1 □ Yes 2 🛣	- No		
	th the 3a or t be n	Funeral Director	10e. Street and Number 4200 Taunton Dr.			10f. Zip Code 207	05		10g. Citizen of W	d States			
	ath wi	nue	11. Marital Status	12. Was Decedent Ever in U	.S. 13. \	Was Decedent of Hispa If Yes, specify Cuban, M		ify Yes or No-		- American Indian,			
Q	ter de	by F	1 Never Married 2 Married	Armed Forces?  1  Yes 2 No		If Yes, specify Cuban, № 1 🏻 Yes 2 🕱 No S		ican, etc.)		, White, etc. Black			
3-003p	urs af tural" af Exa		3 🕅 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.					Specify:				
<u> </u>	72 ho n "na Aedic	Completed	15. Decedent's E (Specify only highest gra	ade completed)	I (Give	dent's Usual Occupation kind of work done during O NOT use retired)	n ng most of working	g	16b. Kind of Bus	siness industry	- 3		
7	within giene. er tha the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	Homemaker			Do	mestic			
פ	filed valued by all Hyg	Be C	17. Father's Name (First, Middle, Last)		•	18		(First, Middle,	Maiden Surname)	<sub>urname)</sub> Wade			
yland	Ment Ment narke	욘	Robert	Jenni	<del>-</del>		Julia						
Mar	2 shou Ith and <b>27 is n</b> traum		19a. Informant's Name/Relationship (T)  Marsha King / Ni	r, City or Town, Sti ${ m elt}$ , ${ m MD}$									
ē,	1 and of Heal item other		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place)		ate		City or Town, State			
Ē	Page nent c ant: If any or		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			ke Cremator	у 6/10	/2010	Be1tsv	ille, MD			
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	iee Mo	1385 E	2. Name and Address o Rapp Funera 233 Gist Av	f Facility 1 and Cr	ematio	n Servic	es 20910			
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	Approximate Interval Between	n								
4	nysician/		Immediate Cause (Final disease or condition	Onset and Death									
	Medical Examiner		resulting in death)	a. Due to (or as a consec									
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	eclden			- winer	15_				
	ited J insit	] E	cause. Enter Underlying Cause (Disease or iiniury	2	. ,								
	icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):								
2	ate be nhysici the bu	dica	_	d									
200	ding p		IF FEMALE:	23c. If yes, outcome of pregr	nancy	*			23d Date	e of delivery			
POX	eath c atten d for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of g ☐ Unknown	tal death 3	☐ Ectopic pregnancy ☐ Other (specify)			Mor				
	the d by the tacher	Phys	9 Unknown		o use contribute to the cause of death?								
,	res thar signed I be de	þ	Part II. Other significant conditions of	ontributing to death but not re	esuling in the t	underlying cause given	III Faitt.			3 ☐ Probably 4 😿 Unkr			
ğ	requi been shoulk	Completed						24a. Was		Vere autopsy findings availarior to completion of cause	able		
ê Ç	he law te has age 2	шо				1			ormed? d	inor to completion of cause leath? Yes 2 \( \sum \) No	9 01		
<u></u>	ian: T	BeC	25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
5	hysic this ce al dire	은	1 ☐ Yes 2 🔀 No  27. Manner of Death	Hospital:	ER/Outpatie				dence 6 Othe				
0	ding F th. After funer	cate	1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year)	injury	work?	s 2 🗆 No	8d. Describe r	now injury occurre	a .			
Division of Vital Records,	r Atten er dea rector: by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	De 28e Place of Injuny - At I		reet, factory, office	2	28f. Location (S City or Tov		r or Rural Route Number,			
É	oital o urs aft ral Di		M						a contated	_			
Cause (Disease or Liffur)  Cause (Disease or Lif											r stated.		
	To the within To the comp		29b. Signature and title of certifier			29c. License nu	ımber		29d. Date signed	(Month, Day, Year)			
	•		M.S.				17874	7	6-0	7-2010			
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, 38 /4	Print)	TAE CI	TY.	MD 20	722			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	DOUBLE COTTA							
	Registr	ar			00	7							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hilliard Physician/ 11:45p William 20 YO May 38 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Larkin Chase Nursing Home Bowie Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. 08-05-1935 North Carolina 237-52-2007 74 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Director MD Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be Funeral with items 23a 15005 Health Center Dr. 20716 USA death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ď X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: Completed 3 🛮 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Landscaper Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hilliard 2 Ferman Hicks Avent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Chase/ Step-Daughter 3020 Brightseat Rd. #103, Lanham, MD 20706 other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ò 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from Department of Important: If any injury or MD. 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 06/10/2010 Cheltenham, Maryland 21. Sign wre of Funeral Service Litensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Congestive Cardiomyopathy disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Year Day Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown P.O. | or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Stroke, Diabetes 1 Yes 2 No 3 Probably 4 X Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and t le of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32261 June 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lev

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) 32. F

32. Registrar's Signature

Dr. Richard Feldman 8116 Good Luck Rd., Suite #300 Lanham, MD

20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 ear June 13, 6:57 A. M Anna Mary Hosford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Lutherville 210 Brightwood Club Drive If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-16-4986 1 M 2XXF Months Days Hours (Month, Day, Year) 11/30/1919 Balt., Maryland 90 Yrs Director Usual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Lutherville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States Funeral 210 Brightwood Club Drive 21093 of America 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes XIX No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3XXWidowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or come. ٥ Arthur Dowell Anderson Hilda Mae Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 N. Aurora Street Easton, Maryland 21601 Mr. Chip L. Hosford/ son 20a. Method of Disposition 20b. Place of Disposition (Name of June 15, 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 Donation 5 Other (Specify) Forest Hill, Maryland 2010 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P. P. 2325 York Road Timenium, Maryland 21093 21. Signature of Funeral Service Licenses sto. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ☐ Live Birth 2 ☐ Fetal 300...
☐ Pregnant at time of death
☐ Unknown in the past 12 months? Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No cate has been sig page 2 should b Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 

Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide
Homicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year

32. Restrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2010 Physician/ Halenar 8:45 10 Ам Pauline June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Angels of Paradise Glen Burnie 8. Date of Birth (Month, Day, Yea February 2, 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. Maryland 219-10-5641 Director 92 1918 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o with Funeral 21060 USA 7808 Baltimore Annapolis Blvd filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 XNever Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Fant: If item 27 is marked other than jury or other traumatic event, the Mental other events and evental other events and events a College (1-4 or 5+) Air Conditioning Factory Worker vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stefania Zvonar William Halenar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Park Avenue Apt 1207, Baltimore, Maryland 21201 niece Donna R. Emorv permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June Data 4. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. methon Part 1. Enter the disease, or complications that r, used the deads shock, or heart failure. List only one cause on e. o. line. 23a. Part 1. Enter the disease Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Physician/ Crean. au cev disease or condition Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Date to fur as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of death? this certificate has performe 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number on who completed cause 30. Name and address of pe of death (Item 23a) (Type, Prift)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month. Day.

Madison

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Herbert Francis	Har	1- For State	State	of Marylar		rtment of tificate of		nd Me	ental Hy		Reg. No	2010	1854	
Physici	an/	Registrar 1. Decedent's Nam	ne (First, Middle,Last)	)					- 7	2. Date of Dea	ath		3. Time of Death	
Medical Exami		Herb	ert F. H	ansel	Jr.					June 9, 20	010	Year	1526 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Tox							on of Death		c. County of Dea			
			uare Hospital				Rosedale			lo Burrello	11 11 11		timore	
Funeral Director		5. Social Security I			. Age (In yrs. la	st birthday)	If Under 1 Y Months D	ear If Ur ays Hou				Fore	rthplace (State or ign	
Director		213-70-	,	M 2 F	54	Yrs.				June	29	,1955 c	ountry) MD	
any		Usual Residence of	of Decedent 10b. County		10c. City.	Town or Locati	on						T 10d. Inside City Limits	
_ 0 W BI		MD	Baltim	ore	1.00.0.0,		Esse	\ <b>V</b>					1 Yes 2X No	
rylanc a-f sh	ctor	10e. Street and Nu		010	<u> </u>		10f. Zip Code				10a. Ci	itizen of What Country?		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If filen 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Director		oxcroft :	Lane			21221					JSA		
with to	<u>ra</u>	11. Marital Status	T T	12. Was Dece	dent Ever in U.S		Decedent of	Hispanic C			<b>)-</b>		rican Indian, Black,	
leath r item	unera	1 Never Marri	ed 2 XMarried	Armed Ford	ces?	If Y	es, specify Cub	an, Mexic	an, Puerto R	tican, etc.)		White, etc.	rah dikin	
after o	by F	3 Widowed	4 Divorced	If Yes, Give Year or Dates:	- (2)	1	Yes 2 🔀 I	No speci	ify:			Specify:	White	
ours.	be T		ducation (Specify onl	y highest grade	completed)	16a. Decedent	's Usual Occup est of working I					Kind of Business	•	
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within piene.	Ę	12tl	(First, Middle, Last)			73313	carre v			First, Middle,	100	arpet C	ompany	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပိ		rt F. Hai	nsel S	r.			18.1000		erine				
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e, N I and Health item		20a. Method of Dis	position	•	20b. P	lace of Disposi	tion (Name of			Date		Location - City o		
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Baltin permit. P Departme Importar injury or			Other Specify: ineral Service Licens	00 (			ame and Addre	_					lto. MD	
Dep Depri	e ()	HALL	7/2/16	Ole	N				30					
Physician		23a. Part I. Enter th	ne disease, or compli	cations that cau	sed the death.	Do not enter th	e mode of dyir	ng, such as	s cardiac or r	respiratory arr	rest, sh	ock, or heart	Approximate Interval Between Onset and	
/Medical	8	Immediate Cause		Hyperte:	nsive a	theroso	leotic	card	liovas	cular	dis	ease	Death	
Examiner		or condition resulti		ue to (or as a c										
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6 be ex ysician burial	edi	23a, 27, per ME g904 6/28/10 TT    X UNPENDED   AMENDED   8 Per H, G904, 6/22/2010, WS     IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery										<u></u>		
876 tificat ng ph as the	ian/Me	23b. Was decedent past 12 months		1 Live bird			al death	B Ecto	pic pregnan	су	23		y Day Year	
x 6 th cer ttendi	ပ				nt at time of dea	ith 5 Oth	er (Specify)				- 10			
J. Box 6876 t the death certificate by the attending phy ached for use as the b	hysi	1 Yes 2 1		9 Unknow						Los Bill				
cords, P.O. B law requires that the d has been signed by the	by P	Part II. Other signi	ficant conditions	contributing to d	leath but not re	sulting in the ui	iderlying cause	e given in	Part I.				the cause of death? bably 4  Unknown	
S, F puires en sign										24a. Was			utopsy findings available	
ord aw rec	ompleted									autop	osy	prior to	completion of cause of	
Rec The Is cate h	ĕ										rmed? 2 ✔ N	death?	es 2 No	
tal Recician: The certificate	BeC	25. Was case refer examiner?						_	th (Check on	lly one)				
of Vit ing Physic After this	2	1 🗸 Yes	2 No			ER/Outpatient		Other <sub>4</sub>				ence 6 Othe	er:	
n of ding Ph After t funeral		27. Manner of Deal		28a. Date of (Month, D	injury ay,Year)	28b. Time of In		jury at Wo		8d. Describe	how in	ury occurred		
ivisior or Attendather death Director:	cation	2 Accident	5 Pending Investigation		- All					06.1	O	- 111 - 1 5	David Novel City	
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	ertific	3 Suicide	6 Could not be determined	(Specify)	of injury - At ho	ne, tarm, stree	, ractory, office	e building,	etc. 2	or Town, S		and Number of R	ural Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	0	4 Homicide 29a. Certifier	Certifying Physicia		of my knowledge	e death occur	ed at the time	date and	place and di	ue to the caus	se(s) as	nd manner as sta	ted.	
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2	Medical Examiner:	On the basis of e	examination an				-					
To To	ě	29b. Signature and		and manner stat	ea		29c. Lice	nse numbe	er		29d.	Date signed (Mo	onth, Day, Year)	
		auest	FOR	VAMEL	A SOV	THALL	0.0	C.M.E.			Jur	ne 10, 2010		
	ŀ	30. Name and addr	ess of person who co	empleted cause	of death (Item 2	23a)		<del>-,</del>			Ц.,			
D V				Assistant M	edical Exan	niner 111	Penn Stre	et, Balti	imore, MI	21201				
		31. Date filed (Mon	th, Day, Year)		strar's Signatur	e								
Regist			UN 15 201	Jan	and to	· ba	Kel							
DHMH 17 Rev 1/20 OCME 2006	001					ORVINAL						OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Garland N. Hoover JUNE /Medical 4c. County of Death 4b. City Town, or Location of Death Facility Name (If not institution, give street and number) Examiner If Unde ider 1 Year 8. Date of Birth (Month, Day, Year 9. Birtholece (State or Foreign (In vrs. last birthday) **Funeral** Hours 1 XM 2 ☐ F 88 Days 507-12-9214 Yrs 20, 1921 Nebraska Nov. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Harford Joppa Maryland Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21085 146 Garnett Road 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ed other than "natural", or items event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Yes 2 No f Yes, Give rear or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. 12 Engineer Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Viola Taylor ို Dovle Leroy Hoover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
146 Garnett Road, Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type. Print) Phyllis A. Hoover / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If it any Injury or c Towson, Maryland Hilltop Service Corp. 6-14-10 22. Name and Address of Facility McComas Funeral Home, P.A. nature pi Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner HLUMATON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examine ementia death certificate be executed attending physician and for use as the burial-transit veus anvens besteven Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the a I□Yes 2□No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gathyrodisin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Wasan autopsy certificate 1□ Yes 2 100 To the Hospital or Attending Physician; within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 3□ DOA P 1 Inpatient 2 ER/Outpatient 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SUP GILL 13 U

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State Registrar

DHMH 17 Rev 1/2001

e and address of person who completed gause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HANKINS James 0136 une 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** how 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours Min. Month Day, Country) 213-20-0135 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 **Y**es 2 □ No MD timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 WNo Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life 100 NOT use retired 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Be affier's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic 19b. Mailing Address (Street and Number or Ru I Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition . Place of Disposition (Name of or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory rownsville, MD 6-21-10 21. Signal re of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARdIAC Ph. sician/ disease or condition resulting in death) mmedby Medical Due to (or as a consequence of): **Examiner** myochildipl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Exam EXSANGUINA TION The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy 1 U Yes 2 No 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural iniury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Day, Year) 0061438 13 2010

State Registrar South Honover St

Baltin

ame and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

BUKOVITZ

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 AM AUREN CARCELLE HARRIS 2010 1219 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CROSS HOSPITA SPRING MONTGOMERY HOLY SILVER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min Month Day Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F 06 Director Usual Residence of Decedent Trismarked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No P.G. COUNTY MARLBORD UPPER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 207 ALAMANCE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PURANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARCELL HARRISIS HARR RIN NEWINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOREST CROSS GLEN 20910 HOSPITA! <u> 1200</u> WD HOI Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service Licensee <sup>22</sup>State Anatomy Board; 655 W. Baltimore Street tector Baltimore, Maryland 21201 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final a EXTREME Filysician/ PREMATURITY disease or condition resulting in death) Medical Due to (or as a consequence of 25 Min Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director. After this certificate has been signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) □ Pregnam
□ Unknown 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PREGNANCY TRIPLET 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 Yes 2 No 2 NN Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **V** No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

CHMH 17 Fov 7/2009

OCKVILLE PIKE, ROCKVILLE MO 2085

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

. ASHKI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Emmet. Howard Month ам Medical 2010 June 3:15 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Gaithersburg Examiner 4c. County of Death
Montgomery 12 Tobacco Leaf Court Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days 577-22-4687 Min. Hours 84 1/277777925 Director Vrs D.C. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material and once. 10a. State 10b County Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg t¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Tobacco Leaf Court 20882 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever III 5.5.
Armed Forces?

1 X Yes, 2 No
If Yes, Give US Marines
Year or Dates 1013-16 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Howard Julia Dowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Tobacco Leaf Court, Gaithersburg, MD 20882 Patrick Howard / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 6/15/2010 Woodbine, MD Signature of Funeral Service i <sup>22. Name and Address of Facility</sup> mary land Cremation Services PO Box 1413, Baltimore, MD 21203 icensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of impury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burialby Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown s been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available certificate has be irector, page 2 s prior to completion of cause of death? autonsy performed? Yes 2 X No 1 Yes 2 No Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2X No. Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home **XX** Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of After 28d. Describe how injury occurred 1X Natural injury 5 Pending n 24 hours after death.

e Funeral Director: Affeted filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Fune

completed fil 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 62234 6/14/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Thambi,

31. Date filed (Month, Day, Year)

MD,

32. Registrar's Signature

9707 Medical Center Dr., Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Jimmy Ray Holman Month 2010 Year June 11 10:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Middle River 20 Right Elevator Drive 8. Date of Birth (Month, Day, 05/10/ 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 ☐ F Months Hours 215-46-5270 63 Director Tennessee Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20 Right Elevator Drive 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 Not S Army
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Automotive 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ellison Thomas Junior Holman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 3762 Timahoe Circle, Baltimore, MD 21236 19a. Informant's Name/Relationship (Type, Print) Celeste Charmaine Holman/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/12/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorrota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box1413, Baltimore, MD 21203 Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Small Cell Physician/ disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examir attending physician and for use as the bunal-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 🗌 Yes 2 🗌 No certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? Other: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 √ Residence 6 ☐ Other (Specify) this s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) D60372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRBZ Rm 563, Baltimore MD 21231 Hann 1550

DHMH 17 Rev 7/2009

Registrar

state of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08<sup>ay</sup> JUNE 2010 EZEKIEL BENJAMIN HOFFMAN Ezekial Benjamin Hoffman 7:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE OF DULANEY TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1171971928 Director 213-26-7468 81 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Completed by Funeral** 6659 SANZO ROAD, APT. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LIFE INSURANCE SALES INSURANCE Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL **HOFFMAN** ANNIE ANSELVICH 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN LOVE/DAUGHTER 2729 QUARRY HEIGHTS WAY, BALTIMORE, MD 20b. FANS HE speed of Way of crematory of other place. 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State AITZ CHAIM CEMETERY : 6/11/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licer see 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final with Metustasis Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မြ 1 ☐ Yes 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ficate of De			eg. No.					
Physici	an/	Decedent's Name (First, Middle,Last)				Date of Dea     Month		3. Time of Death				
Medical Exami	iner	Annecce dones				June 6, 20	010	2110 hrs				
		<ol> <li>Facility Name (if not institution, give street and number</li> <li>734 Mount Holly Street</li> </ol>	)		, Town, or Location of timore	f Death	4c. County of De					
F		•	ge (In yrs. last		nder 1 Year If Under	24Hrs. 8. Date of Bir	N /					
Funeral Director		214 20 7056	50	Mo	nths Days Hours	Min	For	eign Country) MD				
		214-80-7956 1 M 2XF 50 Yrs. Mar. 18,1960 Country) MD										
any		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits 1 X Yes 2 No				
and show	ō	MD N/A Baltimore										
Maryl 28a-1	Director	10e. Street and Number		10f. 2	Zip Code	1	0g. Citizen of What C					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		734 N. Mt. Holly St.			21229		USA					
ath wi	Funeral	11. Marital Status  12. Was Deceden Armed Forces  Armed Forces	?		edent of Hispanic Origi ecify Cuban, Mexican,	in? ( Specify Yes or No Puerto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,				
ter de		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No	1 Yes	2 X No specify:		Specify: T	Black				
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nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene.  It: If item 27 is marked other than other traumatic event, the Medical	Be C	17. Father's Name (First, Middle, Last)		ii Juliane)								
212 Muld be Ment mark	ا 0	Franklin D. Jones  19a. Informant's Name/Relationship (Type, Print)	nber, City or Town, St	y or Town, State, Zip Code)								
MD nd 2 sho alth and m 27 is aumati		Judith Jones/ Daughter	: 1	734 N.	Mt. Holl	y St. Ba	ltimore,	MD 21229				
re, l Heal Fitem er tra		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from Si		ice of Disposition (N								
Pages Pages ment of tant: I		4 Donation 5 Other Specify:		enmount	Cem.	<b>6</b> <del>2</del> /16/10	Baltimo	ore, MD				
Baltimore, permit. Pages I an Department of Hea Important: If ite		21. Signature of Funeral Service Licensee		22. Name a	nd Address of Facility	Chatman-H	Harris Fu	neral Home				
	8 8	23a. Part I. Enter the disease, or complications that caused	d the death D	4210	Belair	Road Balt	imore, M	ID 21206 Approximate Interval				
Physician /Medical		failure. List only one cause on each line.						Between Onset and Death				
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	iner	if any, leading to immediate Due to (or as a cons	equence of):									
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D, be ex sician	Medical	X UNPENDED X AMENDED 2	Jb per Sa,FII,	th g904 27, per	6-15-10, vt ME g904 6	/30/10 TT						
376( ificate ig phy s the b	M/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco	me of pregnan	ncy 2 Fetal dea	th 3 Ectopic	pregnancy	23d. Date of deliver Month	ery Day Year				
Box 687 e death certific the attending	/sician/	past 12 months?	t time of death					,				
BO te deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown										
i, P.O. Bo ires that the des signed by the a	by P	Part II. Other significant conditions contributing to deal	h but not resu	alting in the underly	ng cause given in Par			to the cause of death?				
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sied in by the funeral director, page 2 should	Completed		_		·	autop		o completion of cause of				
Vital Rec ysician: The l his certificate l	S				00.00	1 ✓ Yes		Yes 2 No				
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n of V ling Phy After thi funeral d	<u>۲</u>	1 V Yes 2 No 27. Manner of Death 28a. Date of Inj. (Month, Day.)		8b. Time of Injury	28c. Injury at Work?		how injury occurred					
On C ending ath.	tion	Natural 5 Pending	/ear)		1 Yes 2	No						
ViSi or Att fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Ir	njury - At home	e, farm, street, facto	ory, office building, etc	28f. Location (Sor Town, S		Rural Route Number, City				
Division pital or Attent ours after death feral Director: filled in by the	Certification:	4 Homicide determined (Specify)				or rown, s						
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physician: To the best of m one) Certifying Physician: To the best of m Medical Examiner: On the basis of examiner: On	y knowledge,	death occurred at	the time, date and place	ce, and due to the caus	se(s) and manner as s	tated.				
To th within To th comp	Medical	2 weetical Examiner. Of the basis of example and manner stated.	mination and/		29c. License number		29d. Date signed (i					
	2	255. Signature and title of certifier		['	O.C.M.E.		June 8, 2010	way, rour				
		30. Name and address of person who completed cause of	death (Item 22	Ba)			1					
		Ana Rubio MD. Assistant Medical Exar			, Baltimore, MD 2	21201						
St	ate	31. Date filed (Month, Day, Year) 32. Figistra	ar's Signature		Н							
Regist	rar	HIN 1 5 2010 Perce	11 1	back								

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 2300 ADDIE **JETER** Month 2010 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S . Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 - M 2 - F Hours 578-46-2166 89 JUNE 19 Director °1920 SOUTH CAROLINA Usual Residence of Decedent show 10a State with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 X Yes 2 No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 5216 CALL PLACE S.E. 20019 USA death v 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. ģ 1 Never Married 2 Married 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after Specify: BLACK 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 ☑ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 6TH HOUSE WIFE PRIVATE Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MOZON CHEEKS MARTHA ANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN JETER/SON 5216 CALL PLACE S.E. WASHINGTON, DC 20013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 6/12/2010 LANDOVER, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME colle My LANDOVER ROAD LANDOVER MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATAL disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 🏝 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pendina work? 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) DAV15

State Registrar

GRIFFIN

31. Date filed (Month. Da

3001

MD

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2010 Franklin Eugene Jarrell, Sr. 3:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4525 Greencove Circle Edgemere Baltimore Co. 8. Date of Birth (Month, Day, Aug. 10 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F 216-38-7408 Months , 1940 <sup>Country)</sup> Mary1and Director Aug. 69 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 36 Admiral Blvd. 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 X Married XX Yes 72 hours after Baltimore, Maryland 21215-0036 should be filed within אביייב. and Mental Hygiene, בישרים other than "natural", 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White Vietnam Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Steel Industry Steel Worker Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary M. Watson Ernest F. Jarrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 36 Admiral Blvd. Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra (Wife) Mrs. Carol A. Jarrell 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 6/11/2010 4 Donation 5 Other (Specify) Lawn Cemetery 21. Signature of Funeral Service Live Budare Ruckes Fulfier al Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the diseas Approximate Interval Between shock, or heart failure. List only one cause on each line mon th Immediate Cause (Final Cance Physician/ Ce disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, ri any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Exam The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of). resulting in death) Last attending physician a for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç ; page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 🗌 Yes 2 🗆 No Physician: Son's 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Residence မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Philadelphia Bood # 208 Bahrani 31. Date filed (Month, Day, Year) 32. Red

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 855 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 0218 2010 Patricia Jean Kirby Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death MEMORIAL EASTON ALBOT to SPITAL AT ZASTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏋 F Months Hours Min (Month, Day, Year, Country)
Maryland **Director** 217-40-1383 8 Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2XX No Maryland Caroline Co Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 East 6th Street 21660 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" 3 ₩ Widowed 4 Divorced Year or Dates White Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Pippin Hemrick Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) East 6th Street Mrs. Denise Y. Price / Daughter 201 Ridgely, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cemetery June 14,2010 20a. Method of Disposition 20c. Location - City or Town, State of o 1 X Burial 2 Cremation 3 Removal from State Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA: 2nd Ave SW: Glen Burnie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hours Medical Due to (or as a consequence of) Examiner months sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last attending physician Physician/Medical on Small ceu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 2 9 ☐ Unknown detached 9 🗌 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes 2 å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XI No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after used...

To the Funeral Director: After this of completed filled in by the funeral directions. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practices: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signala and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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Teal

Drive - Suite 301, Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

520

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Yong Bae Kim 2010 :58 A Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 **X** M 2 □ F Months Days Min. (Month, Day, Year) 586-64-8546 Director 72 Aug. 31, 1937 Osaka Japan Usual Residence of Decedent 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Baltimore County Timonium 1 🗌 Yes 2🏋 No 10e Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 21 Tintern Court unit 203 21093 items 23a Funeral United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify Asian Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineering 12 04 Chemical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Pyung Doo Kim Kap Yuel Kim plnods 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s I Health a Department of Hear, Important: If item 27 any injury or off-once. Mrs. Yang Ja (nee Park) Kim Tintern Court unit 203 Timonium, MD. 21093 20a. Method of Disposition 20c. Location - City or Town, State
(Baltimore County) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 1 XBurial 2 Cremation 3 Removal from State June 14,2010 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral & Chemation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 arr 1. Enter the isease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, surck, or heart failure. List only ine cause on each line. interval Between Immediate Cause (Final Onset and Death Physician/ Odemoaniva disease or condition a. M Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Day to (or as a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Ves 2 No 9 Unknown 9 Unknown ó Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by COLUMBIOSCHOL DECIGOS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has pade 1 Yes 2 No Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 \Boxedat Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deadle occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) sentown

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 11, 2010 9:35 P.M Evelyn M. King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4475 Montgomery Road Ellicott City Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 24 Hours Year 1917 Maryland 214-01-6995 92 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? and Mental Hygiene.
is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be a Funeral 4475 Montgomery Raod 21043 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Specify: 3 ₩Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Audit Department Sears permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ James L. Justice Nellie Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Grice Daughter 14108 Greenview Dr. Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial 6/15/2010 Elkridge, Maryland <sup>22. Name and Address of Facility</sup>
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Commary Physician/ Spase eacs disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine If any, leading to in neclaticause. Enter Underlying Cause (Disease or iinjury that initiated events Duri to (or as a nonsequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Geath in the past 12 months? Month Day Year signed by the a Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 4 \(\to\) Nursing Home 5 \(\overline{\text{Residence}}\) Residence 6 \(\to\) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in any opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 ☐ Medical Examiner: On the bests of examination arrayor investigation, in 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occur. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Hennami, m 6114 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MO 21211 3730 -HERNAUVI, MO Falls 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** OS 30M imin 010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Hospital **Baltimore** Randallstown 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Russia Months 1 X M 2 □ F 218-43-8389 78 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene.
em 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, II a to offer the summitter or with a summi 10d. Inside City Limits 10a. State 10b. County 10c. City Town or Location 1 ☐ Yes 2 X No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Cantata Court Apt. 308 21136 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Tent Manufacturing Economic Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexsey Klyuchkin Pelageya Kravchenko ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Klavdiya Chebrutskaya (wife) 302 Cantata Ct. Apt 308 Reisterstown, MD 21136 Item 27 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ţ permit. Pages Department of Important; If It any injury or o 1 Marial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cemetery 6-16-2010 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 J. Wayne Osterling Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immediate Cause (Final 97 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events would improve that any time in the cause of the cause o Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) 2 No the 1 Yes 9 Unknown ויימוש page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 2 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this ical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 Suicide ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signatura-

30. Name and add

31. Date filed (Month

67

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Old Court Rd. Randallstown, MD 21133

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Elias Medical 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital sells to ۸ده 5. Social Security Number Year If Under 8. Date of Birth Birthplace (State or Foreign Country)
 NC **Funeral** Months Min (Month, Day 246.20.912 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Randallstown MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8915 Greens US A items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? þ Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Black 3 ₩ Widowed 4 □ Divorced Specify: Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Company 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ S. Willoughby Theodore King 19a. Informant's Name/Relations - ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Daster Tevris Kina 29 Greens Lane Randallstown injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6/19/2010 Windsor Will, MD 4 ☐ Donation 5 ☐ Other (Specify) lina Memorial Park 21. Signature of Funeral Service Licensee Vaughn C. Greene Funeral Savice 22. Name and Address of Facility Road Randailstown Mb 21133 23a. Part 1. Enter the shock, or heart to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi tria and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_ in the past 12 months? Day Year Pregnant at time of death
Unknown page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate is completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29c. License number 29d. Date signed (Month. Day, Year) H0055644 13 9010 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Servitive Yorke

31. Date filed (Month, Day,

5401 Old Coopet

Registr

Randallstown

MD

31133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ YUNNU LIU June 12. 2010 4:00 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER Baltimore County Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days 1 □ M 2 🂢 F 81 Months Hours June 8, 1929 Director 218-96-5227 China Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Marvland N/A Baltimore City 1X Yes 2 ☐ No ö 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 1502 East 36th Street 21218 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 X Married Black, White, etc. 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food & Kitchen Helper Restaurant Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ She You Lui Jin Jiao Huang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Chen (Grandaughter 1502 East 36th Street, Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) orraine Park Cemetery 6/17/2010 Baltimore, Maryland Signal de Funda Se Ve Nic se Martin D. Lawson Miltchell-Wiebereld Funeral HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ emu disease or condition Medical resulting in death) Due to (, r s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine If any, leading to immedia cause. Enter Underlying Due to (or as a nonsequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be-Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Jed for L Pregnant at time of death Month Day the 9 Unknown g 🗌 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown scula 24b. Were autopsy findings available prior to completion of cause of death? 12 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at after death. Director: After 28d. Describe hew injury occurred ☐ Natural injury 5 Pending April 15,2010 1 Yes 2 No 2 Accident 3 Sulcide unknown filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1502 F 36+h S Saltimov MD 2121 4 Homicide determined building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di completed filled in Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 2010

State Registrar cause of death (Item 23a) (Type, Print)

32. Pigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 10:26 A M Medical Tuni 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hookins Barview Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth Funeral Months Hours Min Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a hours after death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No and Mental Hygiene. is marked other than "natural", 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Atherosclerotic Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events. Examine Due to (or as a surisequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

June 10, 2010 29c. License number Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 11) H9H0 Bastern Avenue, Battimore, MD, 21224 Najano

DHMH 17 Rev 7/2009

State

Registrar

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** Alma Levee lune 20/0 Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Square Rosea 0 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number & Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 8. Date of Birth (Month, Day, Year) November 16, 1933 Months Days Hours 1 □ M 2 X F 216-32-3582 76 Director Usual Residence of Decedent 10a State 10h County 10d Inside City Limits 10c. City. Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at Director Dundalk 1 ☐ Yes 2 ☐XNo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7816 St. Fabian Lane 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married /TI/VIQ LeVEE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Cook Tillie Zika ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health Department of Health a Important: If item 27 is any injury or other tra Melvin Levee Sr. 7816 St. Fabian Lane, Dundalk, Maryland Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2010 21. Jigna e of Funeral Service La Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician requires that the death certificate be Physician/Medical the. use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐Yes 2 No P.0. ed by the a 9 Unknown s been signed b Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Ficile 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law certificate has page 2 autopsy 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ↑ Natural
2 Accident 5 Pending investigation hours after death. 1 □Yes 2 □ No neral Director: A filled in by the fi 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/13/10

DV

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

9000 Franklin 32. Regis ar's Signature

RS 00000

Drive Baltimore 4d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2010 Medical Roberta Elizabeth 06 08 Moore-Broom 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore
1 Year | If Under 24 Hi <u>Future Care Nursing Home</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Hours Min (Month, Day, Year) Director 157-18-1691 85 07 Usual Residence of Decedent 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits NA MD Baltimore 1 X Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>3600 West Franklin Street</u> U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3X Widowed 4 ☐ Divorced Specify Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 4vrs <u>Civil Servant Clerk</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Elizabeth Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Moore-Son Sinclair Lane, Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn 4 Donation 5 Other (Specify) 6/16/2010 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Descar Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriat-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant 2 🗌 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) W, BALTIMORE ST. EET INDER 1940 BALTIMORE, MD 21333 MB 31. Date filed (Month, Day, Year) State 32. Re Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2010 7:30 P Mary Frances McGurrin 8, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 2326 Harcroft Road Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 28 1924 9. Birthplace (State or Foreign Country) PA **Funeral** Months Hours Director 86 198-14-4061 Usual Residence of Decedent 3a or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 🌠 No MD Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ms 23a c must be Funeral 2326 Harcroft Rd. 21093 USA ral", or items 2 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No ori Black, White, etc. Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", If Yes Give Specify: white 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Balto. County Schools 12 6 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Francis Flannelly Alice Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 401 Annette Ave., Stevensville, MD 21666 Joseph M. McGurrin/son Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 6/12/10 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Se vice Lice 22. Name and Address of Facility J. Flagle Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Congestive Heart Failure Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Rher matic ears. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day g 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform this certificate 2 No Yes 2 N 1 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ᅆ in 24 hours after death.

ne Funeral Director: After this in pleted filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. Jon E. Simon, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

29c. License number

54 Scott Adam Road Cockeysville, MD 21030 Suite 104

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M		artment of ertificate o		nd Mental Hyg	giene leg. No.2010	18561			
П	Physici	an	1. Decedent's Name (First, Middle, L Rosie	2. Date of Dea Month June 13	Day Voor	3. Time of Death 2:50 P M							
-	/Medic	di	4a. Facility Name (If not institution, g	MCMa	Death	4c. County of Dear							
	Examir	ıer	Frankford Nursing		,		ltimore		N/A				
	Funeral		5. Social Security Number 6.		ge (In yrs. last birthda		ar If Under 2	Min. (Month, Day	(Year) Co	thplace (State or Foreign buntry)			
	Director		236–44–7835 Usual Residence of Decedent		99 Yrs.			April 1	1,1911 Wes	t Virginia			
	yland Now		10a. State 10b. County		10d. Inside City Limits								
	Sa-f st	Director	Maryland Baltin	more	Dun	dalk				1 ☐ Yes 2X No			
	th with the	al Dire	10e. Street and Number 3601 Sollers Poi	nt Road		10f. Zip Cod	e 21222		10g. Citizen of What Co USA	ountry?			
36	be filed within 72 hours after death with the Maryland that Hygliene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Extrement out by nothing at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 □ Yes 2X If Yes, Give Year or Dates	No	B. Was Decedent If Yes, specify C 1 □Yes 2 💢		in? (Specify Yes or No- Puerto Rican, etc.)					
21215-0036	in 72 hour n "natural" ledical Ex	Completed k	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)							b. Kind of Business/Industry			
212	filed withir Hygiene. other than ent, the M	mo	Elementary/Secondary (0-12)  5 years	Own Home									
land	be d d	To Be C	17. Father's Name (First, Middle, La. Nazereen Petrice	st)				's Name (First, Middle, ie Kimbel	Maiden Surname)				
Mar	nd 2 salth all		19a. Informant's Name/Relationship Boyd Herron	(Type. Print) Son				r or Rural Route Number, Rosedale,		Zip Code) 21237			
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any Injury or othe once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	Removal from State	20b. Place of Dis	position (Name of ematory or other	place) J	une <sup>Dalo</sup> 7, 2010	20c. Location - City or Rosedale,				
Balti	permit. Pages 1 Department of h Important: If ite any Injury or of once.		21. Signalure of Funeral Service Lic	475	- 7	22. Name and Ac	dress of Facility	1 Home Of I	Dundalk,P.A Dundalk,MD.	21222			
***	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that cause ly one cause on each	ino		dying, such as	cardiac or respiratory ar		Approximate Interval Between Onset and Death			
	/Medical Examiner		disease or condition resulting in death)	a Due to (or a	s a consequence of):	7710.							
	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or a	s a consequence of):								
68760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):										
O. Box 68	Phystcian: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 memths? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death at time of death	B□Ectopic pregr Dother (specif			23d. Date of de Month	elivery Day Year			
ds, P.	uires that t signed by d be detad	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause	e given in Part I.		obacco use contribute	o the cause of death?			
Records,	stcian: The law requir certificate has been s irector, page 2 should	Completed					osy prior to death?	autopsy findings available completion of cause of					
Vital	ian: The		25. Was case referred to medical				26 Place	1 ☐ Yes of Death (Check only o	2 No 1 Ye	s 2 No			
>	yslcia lis cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpat	ient 3 DOA	Othor:		ng Home 5 ☐ Residence 6 ☐ Other (Specify)				
	ng ffer inel	tion: T	27. Manner of Death 1	28a. Date of In (Month, E	jury 28b. Time	e of 28c.	Injury at Work? 1 □ Yes 2 □ N	28d. Describe I	now injury occurred	7.			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2   Accident   Acciden										
	he Hospital or n 24 hours afte he Funeral Dir pletely filled in	Medical (	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the bes aminer: On the basis and manner:	of examination and/o	eath occurred at the investigation, in	he time, date an my opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)			
	To the I within 2 To the Complet	M	29b. Signature and title of certifier	)		29c. Lie	cense number	7- 1	29d. Date signed (Mor	nth, Day, Year)			
1	OV		30. Name and address of person wi	o completed cause of	death (Item 23a) (Typ	e, Print)	man	Mood	s load	0 M/121234			
		ate	31. Date filed (Month, Day, Year)	32. Regit	trar's Signature	boules	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Kathleen Marie Marecki 2010 11:25 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Dundalk Examiner 2613 Lynbrook Road Baltimore Co. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** March 9, 1947 Davs 1 □ M 2 🛣 F Months Hours Maryland 214-44-3300 Director 63 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Dunda1k MD 1 Yes 2 KNo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2613 Lynbrook Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2x No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3₺ Widowed 4 □ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importanti. If item 27 is marked other than any njury or other traumatic event, the Monee. Elementary/Seconday (0-12) College (1-4 or 5+) Check Processor Banking Industry 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mary Louise Christy Lawrence Vincent Lo Presti, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 Lynbrook Road Dundalk, Maryland 21 19a. Informant's Name/Relationship (Type, Print) 21222 Diane Marecki (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/12/2010 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final andiovascular Visea Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ၉ 2 No Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d, Describe how injury occurred Natural Accider injury 5 Pending n 24 hours after death.

e Funeral Director: A:
bleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Numer Fractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and due to the cause (s) and manner as stated. (Check within 2 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause or death (Item 23a) (Type, Print) 0 Day, Year) State Registrar

20/02/2

200

21215-0036

Baltimore, Maryland

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:00p Janet McGinnis 2010 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HOEDice ats COM Birthplace (State or Foreign Country)Unk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth **Funeral** Days ept 26, 1945 1 M 2 X F Months Hours Min. 64 Director 216-46-5309 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified a MD Wicomico Salisbury 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 300 Lemmon Hill Lane 21801 USA Was Decedent Ever in U.S Armed Forces?UNK 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married Yes 2 🗌 No Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be land 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coastal Hospice at the Lake 351 Deers Head Hospital Road; Salisbury, MDtimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state Ronald S. Wade 22 Name and Address of Facility Board; 655 W. Baltimore Street Baltimore, Maryland 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ck, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CHRONIC PHLMONARY Pnysician OBSTRUCTIUR disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or se a consecuence of) Exami attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 🔲 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes death? certificate 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence မ ER/Outpatient 3 DOA 6 Other (Specify) 1 Inpatient 2 I this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Human 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month () 6 Day 06 22010 2:45 PM Regina McNeill 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death alisbury DICE at the If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Age (In yrs. last birthday) Min. 1 □ M 2 🖾 F Days Hours Oc(1401151,1Pay, 184936 Mary Yand 73 213-34-0238 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits MD Wicomico Nanticoke 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20417 Nanticoke Drive 21840 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2X Married 1 Yes Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) public service politician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Rita Shipley Luther Ellis Justis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harris McNeill/spouse 20417 Nanticoke Drive; Nanticoke, Maryland 21840 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ₺ Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 21. Signature of Fu all S Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final a. ADBNOCARCINOUS BRAIN MRTASTATIS disease or condition resulting in death) WITH Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year

Physician Medical **Examiner** 

Physician/

Medical

Examiner

**Funeral** 

**Director** 

or 28a-f show notified at

Director

Funeral

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Completed

Be

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72 hours after death with the Maryland

permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once.

Baltimore, Maryland 21215-0036

Mc Neill

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran ed by the a ate has been signed page 2 should be det certificate I director, this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

Division of Vital Records, P.O. Box 68760

Examine To Be Completed by Physician/Medical Medical Certificate:

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ce HUUAM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOP

Registrar's Signature

WAMS

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	
Part II. Other significant conditions		contribute to the cause of death?
	24a. Was an autopsy perform 29 1 Ves 2 No	4b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes ☐ No
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence	Bther (Specify) HOSPICA
27. Manner of Dath Natural 5 ☐ Pending 2 ☐ Accident Investigati		curred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28e Place of Injury - At home form street factory office 1 20f 1 contion (Street and Mur	mber or Rural Route Number,
(Check / 2 Medical Example (Check / 2 Medical Example )	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and use Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and	I due to the cause(s) and manner stated

D005 8410

29d. Date signed (Month, Day, Year)

180 -

State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OShyA Day Physician/ 55 O M Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner City, Town, or Location of Death KANDAIIStowA DAIE 13 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In vrs. last birthday) 1 🗆 M 2 🗶 F Days UKRAINE 0872071910 99 Director 220-37-0261 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral UKRAINE 21209 1892 AUTUMN FROST LANE death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, et ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Specify. Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev UNOBTAINABLE MOSHES KLARA JULIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1892 AUTUMN FROST LANE, BALTIMORE, MD IRINA FISHMAN/GRANDDAUGHTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State <sup>206</sup> ARE TROTON (CHIZUK 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD AMUNO CEMETERY 6/13/2010 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Emysician** disease or condition Medical resulting in death) Due to (or s a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or/as a consequence of and I-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? è Division of Vital Records, Hospital or Attending Physician: The law requires cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? inpatrent toxue 2 14 No |요 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 1004337 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XITE 203 PEATIMORE, MID

State Registrar KAHTEN

31. Date filed (Month, Day, Year)

W

XMITH

2835

Morning MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Helen W. Novak Jüne 8:36 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 F (Month, Day, Year) Illinois 049-18-9657 95 Yrs. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20814 USA 5225 Pooks Hill Road 411-S 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 □ Divorced item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) High School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UNK. Albert Waudzala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum John A. Novak, Son 5225 Pooks Hill Road #1509-S Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/10/10 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland . Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): 000 The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) 50 resulting in death) Last Physician/Medical IF FEMALE: (3 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics of Vital funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident IK 5 Pending work' Division 2 🗌 No 1 Yes Investigation
6 Could not be completed filled in by the ☐ Acciden☐ Suicide T 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. NON (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29d. Date signed (Month, Day, Year) 29b. Signat 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Bethesda, Maryland 20814 Natasha Haag 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	arylari		tificat			ivieii	nai my	Reg. No.	0 13 1	Ü	18	567
	Physicia	an		e (First, Middle, Las								Date of De Month	Day		Year	3. Time o	
	/Medic	al	Cha	4b, City, Town, or Location of Death				ine	14,		2010 3:45						
	4a. Facility Name (If not institution, give street and number)  3 Austin Rd.									terst					timo	re	
	Funeral		5. Social Security N	e (In yrs. I	ast birthday)	If Unde Months		If Under 24 H Hours Mi	rs. R I	Date of Bi Month, D	rth av. Year)		9. Birthpl	ace (State	or Foreign		
	Director		213-28-	0894	<b>X</b> M 2□ F	79	Yrs.	WOTHERS	Days	110010	Ma	<b>r.</b> 1	3, 1			ýlan	
	land ow		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation							10	d. Inside C	City Limits
	Mary	tor	MD	Balti	more		R	eist	ers	cown						1 ☐Yes	<b>X</b> XNo
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	death with the Maryland ms 23a or 28a-f show Fraist be notfilled at	ral	3 Aust	tin Rd.						136				.S.P			
	ltems	<b>Funeral Director</b>	11. Marital Status	ied XZX Married	12. Was Decedent E Armed Forces?		S. 13. \	Nas Dece f Yes, spe	dent of Hi cify Cuba	spanic Origin? n, Mexican, Pu	(Specify erto Rica	Yes or N n, etc.)	D-	14. Race Black	- America , White, e		
-0036	within 72 hours after death with the Marylan Jene. Itan" inatural", or Items 23a or 28a-f show The Modeal Examiner nast by nuffind at	ρχ	3 ☐ Widowed	2222	YYes 2 ☐ N NYes, Give Year or Dates:	Kor	ea 1	1 ☐ Yes	2 <b>X [X</b> ]0	Specify:				Specify:	Wh	ite	
2	72 ho	eted	(Spec	15. Decedent's Ed cify only highest gra-	lucation		16a. Deced	dent's Usu	al Occupa	ation Juring most of v	vorkina		16b. Ki	ind of Bus	iness/Ind	ustry	
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7	it the	ပ္ပ	17. Father's Name	(First, Middle, Last)			FO	Leme		18. Mother's N	lame (Fil	rst, Middle	e, Maiden				
ב	D ⊕ D ⊕	To Be		1 Harry					:	Kather	ine	E1i	zabe	eth (	Wag	ner)	
Mary	2 should and Mei is marke aumatic			ame/Relationship (7			19b. Mailir	ng Address	(Street a	and Number or	Rural Ro	ute Num	ber, City o	or Town, S	State, Zip	Code)	
e, ≅	9 ± 5 =				pel/Wife	_				d. Rei		rsto					
	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disp XXBurial 2	□ Cremation 3 □	Removal from State	20b. P.	lace of Dispo emetery, cren arrisc	sition (Na natory or c On F	me of other place O <b>Yes</b>	t	Date	/10		ocation - C	•	vn, State	MD
Баппо	nit. Pa artmei ortant injury			5 Other (Specify		Vet	erang	Ce	mete	ry so acility E	/17/			_			
r C	Depariment Deparement Important International Internationa		) I Signature	Kire	Thur	nu				sterst							
			23a, Part 1, Enter the	he disease, or comp	plications that caused one cause on each lir	the death	n. Do not ent	er the mo	de of dyin	g, such as card	diac or re	spiratory	arrest,			Approxima Interval Be	te tween
-	Physician		Immediate Cause ( disease or conditio	(Final	Lu	na	Co	MC	ev	•						Onset and	Death GVS
1	/Medical Examiner		resulting in death)		Due to (or as	a comuqu	uence of):										•
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08/0 <b>0</b> ,	rificate be executed g physician and as the burial-transit	edical			d												
	certifii iding p		IF FEMALE:		23c. If yes, outcome	of pregna	ncv							22d Date	of delive	rv.	
Š D	Attending Physician: The law requires that the death cer sedeath cardeath.  rector: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Physician/N	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Vec 2 No.  4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery  Month Day Year					
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'n.	es tha igned be def	by P											Be. Did tobacco use contribute to the cause of death?				
ecords	requir	ted									-	1,25	Yes 2	s 2 No 3 Probably 4 Unknown			
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N (al	n: Th ificate or, pag		OF Mos assa refer	red to medical						00 DI 15		1 □Yes	2 No	1	□Yes	2 □No	
5	/sicia s certi directo	o Be	25. Was case reference examiner?		Hospital:	ent 2 🗆	ER/Outpatier		Othe	26. Place of I	· · ·			6 □Othe	er (Snecifi	()	
5	ig Phy ter thi	n: To	27. Manner of Deat	h	28a. Date of Inju (Month, Day	ry	28b. Time of		28c. Injun Work	/ at			how inju			7	
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N   S	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju- building, etc	ry - At ho c. <i>(Specif</i> )	me, farm, str	eet, factor	y, office		28f.	Location City or To	(Street ar Swn, State	nd Numbe e)	er or Rura	l Route Nu	mber,
ר	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director. It		29a. Certifier	Certifying Ph	ysician: To the best of	of my kno	wledge, deatl	h occurred	at the tin	ne, date and pl	lace, and	due to th	e cause(s	s) and ma	nner as s	tated.	
	n 24 h	Medical	(Check only one)		niner: On the basis of and manner sta	f examina											(s)
	vithi To th	ž	29b. Signature and		Dr. a.		115		c. License					- r		Day, Year)	
			• Cui	vert	· North	un	MD	1	100	5987	5		6	114	1//	0	
•	10+1	82	30. Name and addr	ess of person who	completed cause of d	eath (Item	23a) (Type,	Print)	ina	iles s	1 #	20	3	BAL	ti mo	261	MD
	Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registra	ar's Signal	ture /	/						0	100	]	
	Registra	ar		111ki 1 K	7010 12	care a	11	MARI	Lad.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ole Physician/ 10:55pm James Nettles Medical Facility Name (if not institution, give street and number, County of Death Examiner nashal Hospice at the lispur vicanuco 8. Date of Birth (Month, Day, Yea Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hg 9. Birthplace (State or Foreign Country)UNK **Funeral** 1 🖾 M 2 🗆 F Months Hours 213-34-4008 73 Director 1937 Jan Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits 10a, State Director MD Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 105 Times Square 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Statusunk 12. Was Decedent Ever in U.S Armed Forces?UNK 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No black 1 ☐ Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation unit 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk Maryland ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 351 Deers Head Hospital Road; Salisbury, MD 21801 Coastal Hospice at the Lake Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State . Signal Do of Funeral Service 22. Name and Address of Facility State Anatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCIRA Physician MALIGNANT COLON disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No detached 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tes 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Peath 28b. Time of 28c. Injury at wo<u>r</u>k? 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending Natural 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 HURM WAS 733

Registrar

State

31. Date filed (Month, Day, Year)

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** May 28 2010  $P^{M}$ Adelaide Newburger 2:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Roland Park Place Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🛛 F 116-22-9957 93 Jan 10, 1917 Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2- No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ö Be 830 W. 40th Street 23a 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, th. Medi al Examiner must Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 social worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph King Vivian Hecht 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2031 E. 31st Street; Baltimore, Maryland 21218 Richard Eisenmann/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 21. Signature | Funeral Ser 22. Name and Address of Facility ice Licensee State Anatomy Board; 655 W. Baltimore Street S. Wade 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Charles (Final disease or condition resulting in death)

Baltimore, Maryland 21201

Baltimore, Maryland 21201

Septis Approximate Interval Between Onset and Death **Physician** Medical / INFECTION **Examiner** Tract WYMAYY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the as ed by the attending detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hypertinsion 2 Probably 4 Unknown 1 Yes page 2 should Completed been Anemia 24a. Was an 24b. Were autopsy findings available prior to completion of death?
1 ☐ Yes 2 ☐ No autopsy HypoTH 4YOID 15M perform certificate funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 to ther (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Records, Division or Vital after death Director: filled in by Hospital

Baltimore, Maryland 21215-0036

24 hours a completely To the l

29b. Signature and title of certifiq

29a. Certifier

(Check only one)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

D35102

28.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 north CHarles Street Baitmore Maryland m.D

Hilary Don 31. Date filed (Month, Day, Year)

32. Fegistrar's Signature

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Kenlie Alexa Osipowicz Certificate of Death 1- For State Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 0138 hrs Kenlie Alexa Osipowicz Medical Examiner June 8, 2010 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** reign Country) Months Hours May 15, 2010 Director 218-87-4621 2 X F Maryland 1 M Yrs 25 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a State s 23a or 28a-f show e notified at once. 1 Yes 2 X No Maryland Harford Edgewood filed within 72 hours after death with the Maryland rector 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code U.S.A. Ճ 21040 1908 Hanson Road Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White 3 Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th None None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessica Marie Perterson Jack Peter Osipowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Hanson Road, Edgewood, Maryland 21040 Ms. Jessica Peterson (Mother) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition June Date 13. Baltimore, 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel 2010 Forest Hill, Maryland Bel - Air 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licens 22 Name and Address of Ficility hapel & Cremation Services Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Asphyxia due to Overlay Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and tran Physician/Medical **AMENDED** UNPENDED attending physician or use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≦ 1 Yes 2 V No 3 Probably 4 Unknown ۵ pleted Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy The law r death? Com ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other: 2 V ER/Outpatient 3 DOA Inpatient this 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Bed-sharing with adult FOUND: Natural Division 1 Yes 2 ✔ No 5 Pending death. the Jun 8, 2010 0105 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Suicide 6 Could not be or Town, State) 1908 Hanson Road, Edgewood, MD determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 9, 2010 ( West O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 2 Registra s Signature State lyeur Registra

Medical Examiner Funeral Director or 28a-f show death with the Maryland Examiner must be notified at 23a "natural", or items Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I John Burns Doyle 19a. Informant's Name/Relationship (Type, Print) Evelyn Frederick/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 8 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Ronald Raltimore, Immediate Cauce (Final MYOCARISIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events use as the burial-tran Due to (or as a consequence of) resulting in death) Last signed by the attending physician by Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant PAPPATHOMIDES 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No 4 Pregnant a 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed peen s within 24 hours after death.

To the Funeral Director: After this certificate has page 2 25. Was case referred to medical examiner? funeral director, Be Hospital: Other: ဂ္ 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at X Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2ď°0 Physician/  $\mathbf{J_{une}^{Month}}$ 11:38 PM Mary Pappathomides 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Inc. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min. May 10, Year 918 1 🗆 M 2 🗆 F MaryTand 92 220-03-1706 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Director 1 Yes 2x No Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21228 707 Maiden Choice Lane #7G04 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: white 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hochschild Kohn sales clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Adelaide Wineke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8129 Pinehurst Harbour Way; Pasadena, MD 21122 20c. Location - City or Town, State <sup>22</sup> Name and Address of Facility Board; 655 West Baltimore Street Maryland 21201 23a. Fert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform 1 ☐ Yes 2 ☐ No 2 **X** No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 \(\mathbb{Z}\) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year 2010 or Location of Death 4c. County of Death 4a. Facility Name (If pot institution, give street and Baltimore ltimore If Under 24 Hrs. 8. Date of Birth Sept 10, If Under 1 Year 9. Birthplace (State or Ford Country) unk 5. Social Security Number Days Hours 1**X** M 68 218-36-5492 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2X No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 4017 Liberty Heights Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupationunk

16a. Decedent Usual Occupationunk

16a. Decede 16b. Kind of Business/Industry 11nk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mo life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname)unk 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Liberty Heights Nursing & Rehab 4017 Liberty Heights Avenue; Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation Other (Specify) in state 22. Name and Address of Facility State Anatomy Board; 655 West Baltimore Street eLicensee S. Wade Ronald Director Baltimore, Maryland 21201 23a. Part 1. Inter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau I Final disease or condition resulting in death) DYSPHYTHMIA CARD/AC Due to (or as a consequence of): CARDIOVASCULAR DISCASE HPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): -SSENTIAL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 [] Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown GRIPHERAL VASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner that the death certificate be executed sician and burial-trans attending physician for use as the buria ed by the a detached f signed to icate has been siç 7, page 2 should b certificate **Division or Vital** director Hospital or Attending

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be မ

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

4 ☐ Homicide

(Check only one)

29a, Certifier

**Funeral** 

Director

Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

jes 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", or ite

ltimore,

Bal

Pages 1

permit.

Physician

/Medical

death. Director: within 24 hours after
To the Funeral Direcompletely filled in by hours after

> State Registrar

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

and manner stated.

2010

LINDEN AVE- BALTIMORE -827 32. Registrar's Signature 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2235 Рм 2010 awrence The /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kent Chester River Manor Chestertown 8. Date of Birth (Month, Day, Year) 6 / 25 / 1 9 4 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 578-50-1421 SC 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Multical Exercite and any injury or other traumatic event, If a Multical Exercite and any injury or other traumatic event, If a Multical Exercite and any injury or other traumatic event, If a Multical Exercite and any injury or other traumatic event, If a Multical Exercite and any injury or other traumatic event, If a Multical Exercite and a second a second and a second a second and a second a se 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County MD Kent Chestertown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 103 Trafford Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Black 1 ☐Yes 2 🛛 No Specify <u>م</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beulla Madden Lawrence Richey Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4301 Kansas Ave NW, Washington, DC 20011 Denise Richey - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale Park Cre 6/15/2010 Riverdale, MD 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** chuxia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attur to and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Affetely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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Galing MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamin

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M Martha Rutledge Robbins 7:15a 2010 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Broadmead Cockeysville 8. Date of Birth (Month, Day, Ye Sept 22 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country Maryland Months Days 1 🗆 M 2 🗶 F Min. 214-26-1076 83 Yrs 1926 Director Usual Residence of Decedent or 28a-f show se notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Cockeysville 10e. Street and Number 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be by Funeral 21030 13801 York Road Apt.C-4 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Art Teacher other 1 Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Charles Rutledge Susan Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 13801 York Road Apt.C-4, Cockeysville, MD 21030 John A. Robbins, Jr., Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 6/14/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ MICHONEW Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Records, MARTHA 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 W No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 🐔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 12,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Sanzaro, M.D. 13801 York Road Cockeysville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		Maryland / Dep <i>Ce</i>	artment of rtificate of		F	Reg. No. 2	0 18575					
1	Physic		1. Decedent's Name (First, Middle, La William W. Rhodes	,				2. Date of Dea June	13 <sup>ay</sup> 2016	3. Time of Death 8:30 a <sub>M</sub>					
	/Medi Examii		4a. Facility Name (If not institution, giv		er)	4b. City, Town, Gaithers	or Location of Death	1	4c. County of Do						
	Funeral Director		277 10 7720	ex 7.	Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Pay 4 / 6 / 1 9 2	9. I	Birthplace (State or Foreign Country) OH					
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner aust be notified at	Funeral Director	Usual Residence of Decedent	ry	Gaithersb				10g. Citizen of What	10d. Inside City Limits 1 □ Yes 2∑No					
	th with 23a or	ral Di	403 Russell Ave.	#110		20877			USA						
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating to state by notified at once.	d by Fune	11. Marital Status  1 □ Never Married 2 및 Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force NXYes 2[ If Yes, Give Year or Date	No	Was Decedent of If Yes, specify Cub 1 □Yes 2☑No	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		merican Indian, nite, etc. White					
21215-0036	within 72 he iene. than "natu	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	lucation ide completed) College (1-4d 4	(Give	DO NOT use retire	during most of wor		16b. Kind of Busine Federal G	,					
Maryland 2	nuld be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last, Edward Martin Rhoo	Edward Martin Rhodes Susan Ervinia McCoy											
Mar	rd 2 sho Ith and 27 is ma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij												
Baltimore,	Pages 1 and lent of Heali nt: If item 2 ry or other		Alma Kelsey Rhodes, wife  20a. Method of Disposition  1 Burial 2ND Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory  4 Chesapeake Crematory												
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee M00982												
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list and filling, if any, leading to immediate	a. Due to (or a Hall	sed the death. Do not en ine.  Lateral action of the death of the deat	,			rest,	Approximate Interval Between Onset and Death One multiple					
,8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially liet extributes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	annahadi dada											
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 🗆 Fetal death 3[ t at time of death 5[	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су		23d. Date of Month	delivery Day Year					
rds, P.	quires that in signed build be deta		Part II. Other significant conditions of Prostate Ca	ontributing to death	(2)	nderlying cause gi	ven in Part I.			to the cause of death?  Probably 4  Unknown					
of Vital Record	The law require cate has been si page 2 should t	Completed by	Obstructive	Wroft	ethy. Ce	evica	( '	24a. Was a autops perfor	sy prior med? death						
/ital		Be	25. Was case referred to medical examiner?	. regpe	receives	nica		1 □ Yes th (Check only or	2 ☑No 1 ☐ Y ne)	es 2□No					
of \	Physi or this o	ျ	1 ☐ Yes 2 ☐ No 27. Manaer of Death	Hospital: 1 ☐ Inpa 28a. Date of In	atient 2 ER/Outpatie	IL 3 DOA			ence 6 Other (S	pecify)					
Division	ipital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director, I	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of	Day, Year) Injury Injury - At home, farm, stretc. (Specify)	M 1 🗆	rk? ]Yes 2 □ No		treet and Number or	Rural Route Number,					
_	Hospita Hours Funeral tely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	yslcian: To the be niner: On the basis and manner	st of my knowledge, deat s of examination and/or in stated.	h occurred at the to vestigation, in my	time, date and place opinion, death occu	and due to the or arred at the time, or	cause(s) and manne date and place, and o	r as stated. due to the cause(s)					
	To the within 2 To the comple		29b. Signature and title of certifier				se number 24/15		29d. Date signed (Mo						
			30. Name and address of person who I ROBS RT BI	completed cause o	f death (Item 23)) (Type, ACH MI)	Print) 201	RUSSE	LL AV. BURG,	ENUE MD 2	0877					
	Sta	te	31. Date filed (Month, Day (Year),	2010 32. Reg	strar's Signature	backed									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ 10 PM MICHAEL ROSENSTOCK 2010 STEPHEN 06 JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL 7. Age (In yrs. Ias 56 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XM 2 - F Davs Hours (Month Day Year) 1954 Director unk Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 United States 1220 Carroll Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify: White 3 - Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Antiques Self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file 2 Shirly Deloris Jonap Henry Meyer Rosenstock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Washington, DC 20008 Page 1 and 2 sh ment of Health a tant: If item 27 is Peter Rosenstock /Brother 2001 Porter St. NW #303 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jun 11 Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2010 4 Donation 5 Other (Specify) 22. NaCrematries of Bond Funeral Alternatives Signature of Funeral Service Licensee M0144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ SEPSIS disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): PNEUMONIA Examiner MYOCARDIAL INPARCTION DAYS Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown END STAGE RENAL Records, Completed 24a. Was an Were autopsy findings available prior to completion of cause of DIABETES MELLITUS has page 2 autopsy performed? • Hospital or Attending Physician: The P 24 hours after death. • Funeral Director; After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 🖺 No 1 🗌 Yes ပ 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES ODOI JUNE

DHMH 17 Rev 7/2009

State

Registrar

SOUTH

HANOVER STREET BALTIMORE, MD-21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

GANDHI

JUN 1

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or						<b>II Copies</b> Iental Hygi		gible.					
	-	For State Registrar	State o	ı ıvıaryıarı		tificate				eg. No.	1 0	185	77			
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Medica Examine		4a. Facility Name (if not institution, Gilchrist Center	give street and num	ber)		4b. City, To		ition of Death		4c. Count	y of Death altimor	e				
Funeral Director		5. Social Security Number 215–30–3212	6. Sex 1 ☐ M 2 <b>XX</b> F	7. Age (In yrs. la 76	ast birthday) Yrs.	If Under 1 Months	Year If U	Inder 24 Hrs. urs Min.	8. Date of Birth 01/21/193	<b>14</b> ar)	9. Birthpl	ace (State or F <b>Yan</b> d	oreign			
aryland ta-f show ified at	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimor	9	10c. City Balti	y, Town or Loc	ation					10	)d. Inside City I				
with the M 23a or 28 ust be not		10e. Street and Number 8820 Walther Blvd				10f. Zip C			1	10g. Citizen of What Country?						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Marr	Armed For	Э	łf	/as Deceder Yes, specify	Cuban, Me	exican, Puerto	cify Yes or No- Rican, etc.)		ce ~ America ick, White, e					
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buriar	Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live I	come of pregna Birth 2  Feta nant at time of c	ıl death 3 🗌	Ectopic pre					ate of delive	ry Day Yea	ar			
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To the within		29b. Signature and title of certifier	500	)).	2		icense num	395		9d. Date sign		2010				
		30. Name and address of person of DANIEWE DU	BERMAN	mo e	6701	N CHI	ARLES	SITE	SUITE 4	405 8	ALTINI	PE, ND.	21204			
Stat Registra		31. Date filed (Month, Day, Year)	1 5 20 10 <sup>2. Re</sup>	egistrar's Signat	ture A.	Bark	End?									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary L. Rice Month Day 13, 2010 June 4:25 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore County 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 🔀 F Months Days Hours (Month, Da 218-14-0950 86 19.1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Hutzler's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Palardy Frances Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Mrs. Marcella Rossbach(Daughter 2 Warren Lodge Court 1D Cockeysville,MD. 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
(Harford County) 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel and June 14,2010 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Cremetion Services 21. Signature of Funeral Service Licensee Josefrey L. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P
2225 Vol. Pool Timonium, Maryland 21093-2215 Gair, Sr. 23a. Fan 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition mon neeks resulting in death) Due to (or as a consequence of): Due to lor as a consultuing of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

**Director** 

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permit. Page 1
Department of I
Important: If it
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1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.

 $4:25\ A.M.$  Baltimore, Maryland 21215-0036

physician and s the burial-transit Box 68760 attending p requires that the death P.0. IE 13, 201 Records, P. The law Vital or Attending Physician: of : After 1 Division

by Physician/Medical Completed To Be Certificate:

(Check

29b. Signature and title of certifie

Examine

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completed

To the Hospital o within 24 hours af To the Funeral Di

Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autonsy performed? Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) ERNESTINE WRIGHT, 2300 M.D.DULANEY VALLEY ROAD

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

th 2010

rar's Signature 31. Date filed (Month, Day, Year) 32. Rec

Registrar

State of Maryland / Department of Health and Mental Hygierie

For State Registrar

1. Decedent's Name (First, Middle, Last)

Certificate of Death

OFHM

Day

3. Time of Death

2. Date of Death

	Physici /Medi		JEAN	RI	EHM			JUNE	JUNE 13 2010				
	Examir		4a. Facility Name (If not institution, giv Good Samaritan Nu		er		own, or l	ocation of De	ath	4	9. Birthplace (State or Foreign Country) Wisconsin  10d. Inside City Limits 1		
	Funeral Director			6ex 7. Ag □ M 2□XF 9.	e (In yrs. last birthda Yrs.	y) If Under Months	Days	If Under 24 H Hours M		Birth Day, Yea 0, 191	9. B	Country)	
	with the Maryland a or 28a-1 show	tor	Usual Residence of Decedent  10a. State Maryland  10b. County		10c. City, Town or Baltimor								
	h with the 23a or 28 31 be no	Funeral Director	10e. Street and Number 4920 Frankford A	lvenue		10f. Zip 0				_			
920	hours after death with the Marylar turel', or items 23s or 28s-1 show al Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ▼ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 及 If Yes, Give Year or Dates:		3. Was Decede If Yes, speci	fy Cuban	panic Origin? , Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-	Black, Wi	nite, etc.	
5-0	72 hou	eted	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	cedent's Usual	Occupat	ion	vorkina	16b.	Kind of Busines	ss/Industry	
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and 2	d be filed ntal Hygie ed other	Be	17. Father's Name (First, Middle, Last	<u>-</u>	166	cuer		18. Mother's N	lame (First, Mid		-		
Maryland 21215-0036	nd 2 should be filed withi lith and Mental Hygiene. 27 ie marked other than r traumatic event, the M	2	19a. Informant's Name/Relationship (Charles Rehm (Nephew)	Type, Print)								, Zip Code)	
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 iny or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Onation 5  Other (Special		20b. Place of Dis cemetery, co Evans Fun	position (Nam rematory or oti Prail Chap	e of ner place Oel B		Date e 15, 201	0	,		
Balti	permit. Pages Department of H important: if its any injury or of once.		21. Signature of Funeral Service Lice	VIII		22. Name and Evans	Address	of Facility al Chap	el & Crem	ation	Services	Parkville	
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68760,	eath certificate be executed attending physicien and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	<i>,</i> , , , , , , , , , , , , , , , , , ,							
O. Box 68	0 0	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	3 □Ectopic pre 5 □ Other (spe								
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ί	S 00 TO	ToB	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatie	int 2 ER/Outpati	ient 3 DO/	Othor	-			6 ☐Other (S	pecify)	
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Division	9 4 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	street, factory,	office			23d. Date of delivery Month Day Year  e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?					
	Hoi 24 h Fur stely	edical	29a. Certifier (Check only one)	ysician: To the best on the basis of and manner sta	examination and/or	ath occurred a investigation,	t the time in my opi	, date and pla nion, death or	ace, and due to courred at the tir	the cause ne, date a	(s) and manner and place, and c	as stated. ue to the cause(s)	
	To the within To the comple	×	29b. Signature and title of certifier	1	-/	29c.	License	number	00	29d. [	Date signed (Mo	onth, Day, Year)	

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier fon Awuch, mp

D0061789

29d. Date signed (Month, Day, Year) JUNE, 13, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORPAINE OFORI-AWVAHIMD. 5430 CAMPBELL BLVD, STE 214, BALTIMORE MIDELES

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5:03 PM Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner HIMOre 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Months Hours Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City Town or Location Bultimore 10d. Inside City Limits Director 1 ¥Yes 2 ☐ No I0e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Black Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) ignature of Funeral Service Liumsee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Ap ximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastano disease or condition resulting in death) colon Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. P,O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No ξ Day Month Year Pregnant at time of death 4 ☐ Pregnam : 9 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached? 1 ☐ Yes 2 M 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Thombosi 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown venous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗙 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 10, 2010 D0063176

Registrar

DHMH 17 Rev 7/2009

State

Chienyenwa

Manylan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Nwachinemene, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death onth Physician/ 1:45 am lune Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner altemore teme atonsvi 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth

Jan 25, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 M 2 XF 1935 Director 213-30-0094 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Directo 1 Yes 2 X No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e, Street and Number Funeral 21228 513 South Rolling Road United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 ☐ Yes 2 No Specify: White "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 12 <u>Clerk</u> Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ည Naomi Newe11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 South Rolling Road, Catonsville, Maryland 21228 William F. Shipley, Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/15/2010 Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. Signature of Funeral Service Licensee Ananca Heaston BO1 Frederick Road, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Immediate Cause (Final set and Death EREBRO VASCUI Physician/ THEROSCL 1)SEM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available 24a Was an MELLITUS autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 70 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 - Residence 6 - Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 11 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and surface in the surface and place and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatyle and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAETO MI A'SNEE 2835 SUITE 203 21200 HIIMIC Registra 31. Date filed (Month, Day, s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ne 55 **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Date of Birth (Month, Day, Yea May 13, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 5. Social Security Number Min **Funeral** Months Days Hours Iran 71 1939 354-76-5824 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe United States 20878 15701 Cherry Blossom Lane Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give filed within 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 ₩Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be financed and Mental H Hassanali Vernoosfaderani Soghra Hagheghe Pages 1 and 2 should မ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (C) 15701 Cherry Blossom Lane Gaithersburg, MD 20878 Important: If item 27 is any injury or other tra Sepideh Saidi /Daughter Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jun 15 <del>j</del> 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nemeand Address of Facility Funeral Alternatives MO1443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ) ubarachno, d **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trail and Due to (or as a consequence of) physician Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Tectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) 2 □ No page 2 should be detached P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 1 Yes 2 No 1 Tyes 26. Place of Death (Check only one) Physician: 25. Was case referred to medical Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient ၉ 28a. Date of Injury this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: I or Attending P 5 Pending investigation Injury 1 Natural 1 Tes 2 🗌 No 2 Accident filled in by the Director: 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

DHMH 17 Rev 1/2001

State Registrar one)

30. Name an

29b. Signature and title of certifier

31. Date filed (Month, Day,

d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

14/

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month June Physician/ 2ďľo 8:40 PM Thelma Margaret Schnepfe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days August 6, 1912 1 🗆 M 2 💢 F 219-58-6484 97 Marvland **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Timonium Maryland Baltimore 1 🗆 Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1811 Reuter Rd. 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Margaret Krout Richard Edelen Roby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1006 Spa Rd. Annapolis, MD 21403 1006 Spa Rd. Dennis Schnepfe/son 20a. Method of Disposition 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (County) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Most Holy Redeemer Cem. June 16,2010 Baltimore, Maryland Donation 5 D Other (Specify) John O. Mitchell IV, Funeral Services of Dulaney Vally, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons t and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ MAYS Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in literature) Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 After this certificate 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending worl 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L Medical 1 Decertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D64395 JUNE 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHARLES ST, SUITE 4105 BACIMOREMS 21204 DANIEUE DOBERMAN, MO

State Registrar 31. Date filed (Month, Day, Ye

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 3:28 A M Evelyn Virginia Shaver 2010 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore Gilchr<u>ist</u> Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) April 18 Year 1922 1 M 2 D F Months Days Hours Min. Director MD 88 214-26-7762 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 ☐ No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10418 Greentop Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Brown Edna Tracey permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Sicheneder/daughter 9100 Gardenia Rd., Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/15/10 1 Marial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD Dulaney Valley Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Licenses Michael 23a. Part Enter the disc a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) and large covernance Medical Due to (or as a c sequence of): Examiner Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠xe detached the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 200 No certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in 24 hours after death.
the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completed fil (Check certifying Nurse Practioner: To the best of my knowledge, death occurred the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Records, Division of Vital

Saltimore, Maryland 21215-0036

Box 68760

P.O.

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

19,90

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 1445 Carter Aven Straton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Montgomery Suburban Hospital 9. Birthplace (State or Foreign Country) **Indiana** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Hours 10/22/11931 017-24-5970 78 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Tyes 2 No Collier Naples Florida 10e. Street and Number 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with and Mental Hygiene. 34109 U.S.A. 4260 Montalvo Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? 1 X Yes 2 No 1954ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 1959 White. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Telecommunications Executive 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alice Aven Hillyer Hawthorne Straton and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strent of Health a tant: If item 27 is 4260 Montalvo Court. Naples. Florida 34109 Christine Dean Straton/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 06/08/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21, Signature of Funeral Service Licenses \* Annuallarre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Subarachnoid Hemorrhage - Non traumatic disease or condition resulting in death) Medical Examiner Acute Myocardial Infarction Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown Ö been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Ejection Fraction less than 20% 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hypertension this certificate has performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I To Be 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No I X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Straton, 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e of certifie 29b. Signature and ty 29d. Date signed (Month, Day, Year) JADARSHAN SWA 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Sudarshan Siva, 31. Date filed (Month, Day, Year) Registra 's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SMITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Sunrise of Annapolis Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** New York Days Min (Month, Day, Year) 12-02-1915 1 M 2 VF 94 **Director** 219-03-5744 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nigury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12717 Greenspring Avenue 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Smith Louise Rees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet M. Kiilehua Daughter 1510 Farlow Avenue Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Carroll Cremation Ser. 6/14/2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road

NOME Poisterstown, MD 21136 Signature of Funeral Service Licenses 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths?

1 Yes 2 No Month Day Year Unknown Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work's 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty e and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

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State

Name and address of person who completed cause of death (tem

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per th g904 6-15-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ liam 2010 Samuel 03:15 AM Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosbita Baltimore naven 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Birthpiac Country) **Funeral** (Month Qay, Yea Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA exington 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 XNo Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Be unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maj ပ 19a. Informant's Name/Relationship (1)/pe, Print) 19b. Mailing Address (Street and Number or 612 Glynock Brenda Liaons <u> Daughter</u> J 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla 1🗡 Burial 2 🗆 Cremation 3 🗆 Removal from State Jamison -0465 4 Donation 5 Other (Specify) Si nature of Funeral Service Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vanou disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 XV0 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Natural work' 1 Yes 2 No Investigation М Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ource 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Roven Andrew MROWIER Lock BLVd 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ 12, 2010 10:36 PM clune Medical Examiner . City, Town, or Location of Death 4c. County of Death Himore Trat Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F (Month 22-195 30 Hours Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director timore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21231 usA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced nite Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, <u>the Me</u> onday (0-12) College (1-4 or 5+) Be 18. Moì ည 10:36pm informant's Name/Relationship (Type, Method of Disposition Place of Disposition demetery, crematery ☐ Burial 2 Cremation 3 ☐ Removal from State 5-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earl line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequen e of) Examiner lan Sequentially list conditions, Due to (or as a nonsequence of if any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 2 No Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Tes 2 No 2 N Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify, 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis Certifying Nurse Practioner: Ty er: On the basis I examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Praction of the basis I examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at cause of the cause (s) and manner at cause of the cause of th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Regis ar's Signature State Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Londal More If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Sept 2, 1960 Social Security Number 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Mary land 217-48-7091 49 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1<sup>2</sup> Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2021 North Wolfe Street 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. ğ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Un 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) ${\sf unk}$ 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea Palin/guardian 2027 North Wolfe Street; Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify in State cemetery, crematory or other place) <sup>22.</sup> Name and Address of Facility Board; 655 West Baltimore Street re of Ronald Vice Scenses Wade Baltimore, Maryland 21201 Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. r heart failure. List only one cause on each line Interval Between Onset and Death Immediate Callie (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Matcent Be examiner? 2 No Other: Mospile ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Box 68760

P.O.

Records,

**Division of Vital** 

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amend #9,11,12,15,16a&b, 17,18,&19a&b Per Ana Bd G906 \*/02/2010 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 6  $\mathbf{J}_{\mathbf{u}\mathbf{n}\mathbf{e}}^{ ext{Month}}\mathbf{e}$ 20TO 23:15 PM Lawrence Stoll Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country ATTK New Jersey Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** 6. Sex Age (In yrs. last birthday) June 13 pay, Yes 28 Days Hours Min. 1 x M 2 □ 82 Yrs Director 140-20-5407 Usual Residence of Decedent show 10c. City, Town or Location unk 10b. County unk Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director unk<sub>i | Yes 2 | No</sub> MD 10f. Zip Code unk 10e. Street and Number unk 10g. Citizen of What Country? Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white XXWidowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Unix 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry <u>Retail Sales</u> Be 17. Father's Name *(First, Middl*e, Last) <del>unk</del> 18. Mother's Name (First, Middle, Maiden Surname) drik ျှ Sto11 Minnie Fender Charles 19a. Informant's Name/Relationship (Type, Print)

Lawrence W. Stoll TII/son
Southern Haryland Hospital Department of Health a Important: If item 27 is any injury or other trains 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Compation 3 Removal from State 4 Donation 5 State cemetery, crematory or other place) 21. Signature of Euneral Service Licensee 22. State Anatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIL Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner -LONEPHRIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit SPIRATORY and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical ()BSTRVU Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital funeral director, 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) ture and title of certifier 29d. Date signed (Month, Day, Year) 29b. Sign ame and address of person who completed ca f death (Item 23a) (Type, Print) 0 ASHEGOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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	rland f show d at	tor	Usual Residence of Decedent  10a. State 10b. County	_	10c. City, Town or Loc	cation				10d. Inside City Limits		
	h the Man ka or 28a- be notifie	Funeral Director	MD Harfo  10e. Street and Number  1409 Calvary Ro		Bel Air	10f. Zip Code 21015			10g. Citizen of Wh	1 ☐ Yes 2 🔼 No at Country?		
936	o filed within 72 hours after death with the Maryland tal Hygiene. It al Hygiene. It of ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces?	No I	Vas Decedent of H i Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Black,	American Indian, White, etc. white		
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	12 a a 2		19a. Informant's Name/Relationship. Florian Svita Florian Kunase	(Type, Print) k Svita/so					er, City or Town, Sta Marylan			
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4X Donation 5 ☐ Other (Special Control of	cify)	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location - C	ity or Town, State		
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):		100 A 1 100		) IVER			
0	ath certificate be executed attending physician and for use as the burial-transit	ical Examiner	· colle									
Box	eg eg	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome  1  Live Birth 4  Pregnant a	2 Fetal death 3 L	Ectopic pregnand Other (specify)	су	THE THE PROPERTY OF THE PROPER	Maryland 21015  20c. Location - City or Town, State  W. Baltimore Street  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  bacco use contribute to the cause of death?  Yes 2 \( \subseteq \text{No} \) 3 \( \subseteq \text{Probably} \) 4 \( \subseteq \text{Onknown} \)  10 1 24b. Were autopsy findings available prior to completion of cause of death?			
ls, P.O.	uires that the signed by ald be detacted	اج	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause gi	ven in Part I.					
Division of Vital Records,	sician: The law requires that the certificate has been signed by the lirector, page 2 should be detach	Completed						1 🗆 Yes	psy pri ormed? de	or to completion of cause of		
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Xes 2 1 10	Hospital:	ient 2 🗆 ER/Outpatier	Oth	lace of Death (Che er: 4  Nursing I		dence 6 Other	(Specify)		
Jo L	ling Phy ). After thi funeral		27. Manner of Death  1	28a. Date of inju (Month, Da	ıry 28b. Time of injury	28c. Injur worl	y at	1	how injury occurred			
ivision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Certificate:	2 X Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	28e. Place of Inj building, et		eet, factory, office	res 2201 No	City or To	wn, State)	or Rural Route Number,		
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of	my owledge, death	tigation, in my opini	on, death occurred	and due to the ca	and place, and due t	as stated. o the cause(s) and manner stated.		
	To the within To the compl	2	29b. Signature and title of certifier	in. n		29c. Licens			29d. Date signed (	Month, Day, Year)		
			30. Name and address of person who	o completed cause of c	leath (Item 23a) (Type, F	Print)	mp.	35010				
	Sta Registr		31. Date filed (Month, Day, Year)	1	ar's Signature	white.						

SVITAY, ARELIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day Month **Physician** P M 10 2010 or ent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 3, 1 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2X F 493-28-0756 81 Yrs Arkansas 1929 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits show 10a. State 10c. City, Town or Location or 28a-f shore MD Baltimore Parkville 1 ¥ Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ms 23a or must be **USA** 2643 21234 Wendover Road Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: ģ 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry er than "nature the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c Pierce Daily Alvas ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once, 2643 Wendover road, Parkville, MD 21234 Emma J. Hill / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 6/14/2010 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a conse uence of): Physician disease or condition resulting in death) t /Medical EXAMINER **Examiner** tracture CERTIFICATION APPROVED BY MEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Accidental physician and is the burial-trans that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 38 IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Year for in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Month Day 5 Other (specify) detached 1 Yes 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ite has been signed page 2 should be di Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death Check only one Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \) Nursing Home \( 5 \) Residence \( \) 6 \( \) Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 4 2010 12 00 PM 1 ☐ Yes 2 X No Accidenta after death. Director: Af 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Home 2643 Wendover Kd Baltimore MD filled 24 hours a Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name

and address of person who completed cause of death (Item 23a) (Type, Print)

2010

600 North Wolfe St, Baltimore, MD, 21287

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please ame	Type or Pring item 5 State of Ma				II Copies Ilental Hyg	Are Legible.	1 -0503		
		Registrar			Certificate of	Death		eg. No. U U	00000		
Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of Dea Month	Day Year	3. Time of Death		
/Medic	al	CAROLE PHYLLIS				1 " (D#-	.0, 2010	9:30p <sup>™</sup>			
Examin	er	4a. Facility Name (If not institution, given 812 N. BENTALOU			BALTI	or Location of Death		N/A	atri		
Funeral		5. Social Security Number 3410		e (In yrs. last birti	nday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	rthplace (State or Foreign		
Director		212-44- <del>3710</del>	1□M 2\XF	65 Y	rs. Months Days	Hours Min.	(Month, Day 4-17-1		ountry) AMYLAND		
pu »		Usual Residence of Decedent  10a. State 10b. County							10d. Inside City Limits		
laryla sho	ō	10a. State 10b. County		10c. City, Town	or Location				1 XYes 2 No		
the M	Director	MD N/A  10e. Street and Number		BALT	MORE 10f. Zip Code			l0g. Citizen of What C			
Ma of			. cm				'		odiniy.		
ns 23	Funeral	812 N. BENTALOU	12. Was Decedent E	Ever in U.S.	2121 13. Was Decedent of If Yes, specify Cul		pecify Yes or No-	USA 14. Race - Am	erican Indian,		
after o		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo			Rican, etc.)				
be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the the stern incomet be notified.	d by	3 ₹ Widowed 4 □ Divorced	If Yes, Give 11 Year or Dates:		1 LlYes 2√2 No	Specify:		Specify: B1	LAUK		
72 he	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a.	Decedent's Usual Occu	e during most of work	ing	16b. Kind of Business	s/Industry		
vithin the. <b>.han</b>	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use retir	red)					
iled v Hygid ther t	ပိ	-12- 17. Father's Name (First, Middle, Last	-0-		LABORER	18 Mother's Nam	e (First, Middle.	<u>MALCO</u> PLA Maiden Surname)	ASTICS		
d be ental	9 Be	JOHN LATTIMORE	,				M. LEE	,			
shoul nd M mari nmari	은	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Stree			r, City or Town, State,	Zip Code)		
nd 2 alth a 27 is 27 is ir trai	Щ	KURT TAYLOR (SON	1)		12 N. BENTA			-			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examination must be multipled anonce.		20a. Method of Disposition	7	20b. Place of cemeter	Disposition (Name of crematory or other plant	ace)	Date	20c. Location - City o	r Town, State		
Page nent ant: If ury o		1 ☑ Burial 2 ☑ Cremation 3 ☐ 4 ☑ Donation 5 ☑ Other (Speci	JRemoval from State fy)	I	MEMORIAL F		-2010 H	BALTIMORE,	MARYLAND		
eparti eparti nporti ny inj		21. Signature of uneral Service Lice	JONATHAN		E <b>₽</b> . Name and Add	ress of Facility RED	D FUNERA	AL SERVICE			
20 E E 9		1 / out	OHUS		1721–27 N	. MONROE	ST. BALT	TIMORE, MAI	RYLAND		
Example of the control of the contro	ical Examiner	Imme of the Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate tause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence o	f): f):	Con Ca	no		20 month		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1		23d. Date of d Month	elivery Day Year					
v requires that the d been signed by the should be detached	by	Part II. Other significant conditions	obacco use contribute l'es 2 ☐ No 3 ☐ I	to the cause of death?  Probably 4 Inknown							
:: The law re icate has bei ; page 2 sho	Completed						24a. Was a autop perfor 1 □ Yes	sy prior to death?			
siciar certif	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea					
ding Phys h. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day		ime of jury 28c. Inj	4 U Nursing H		dence 6 ☐ Other (Sp now injury occurred	pecify)		
The part of the pa											
he Hospit in 24 hours he Funera pletely fille	Medical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of mîner: On the basis of and manner sta	f examination and	death occurred at the	time, date and place y opinion, death occu	e, and due to the irred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
To t With To t	N	29b. Signature and title of certifier	n the	mA	۵	20396		29d. Date signed (Mod	nth, Day, Year)		
HV		30. Name and address of person who	completed cause of d	333 N	Coloner	t st. 1	Belto.	ma	21218		
Sta Registr	ar	JUN 152	010 Janes	a s signature	backs						
HMH 17 Rev 1/2	001			~							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year TUCKER Physician 5 A JUANITA 03 2010 06 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Gardens Nursing Home N/ABaltimore If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 213-52-9293 7. Age (In yrs. last birthday) 6. Sex **Funeral** 11,1920 Virginia Months 90 Days Hours 1 □ M 2 🕅 F Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 10a. State 1 TYes 2 □ No N/AMD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be 2820 Ashland Avenue 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify. Specify: Black Completed by 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th Grade College (1-4or 5+) the Own Home Housewife . Pages 1 and 2 should be filed wi ment of Health and Mental Hyglen tant: If item 27 is marked other th jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Fowlkes Clara Webb ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 N. Streeper St. Baltimore, MD 21205 John L. Tucker, Sr./ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Bapt. Ch. Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Department o Important: If any injury or Blackstone, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 4210 Belair Road Baltimore, MD 21206 ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diseane Corman **Physician** /Medical Due to (or as a consequence of Examiner Earle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and Due to (or as a consequence of): burial Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Italeme Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jonn 24a. Was an ate has b performed' certificate 2 JN0 won **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2140 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔛 ertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 31464

State Registrar

DHMH 17 Rev 1/2001

821 N.

EUTAW ST Smte JOS BALTIMORE MID 2720

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASHMI MD

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year JULL 30 ~ M Medical 4a. Facility Name (if not institution, give street and number) 010 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba thinore Randall Stown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F 05/28/1980 213-96-8774 Director Yrs 5 2 Usual Residence of Decedent 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director Windsor Mill Baltimore MD 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 21244 USA 8304 Lages Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Accounting and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Easton Larry Troy Susan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8304 Lages Avenue, Windsor Mill, MD 21244 Antoinette Troy / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 6/11/2010 Woodbine, MD 4 Donation 5 Other (Specify) Final Journey Crem. 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Lice Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ mehorbors Medical resulting in death) Due to (or as a consequence of): Examiner C 0-01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events ШX Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be 68760 attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box ( Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ō in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) acyllere P29085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 J-0 0 GOUNT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jun 60 724 M 0105 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Lacation of Death Betherda 14 7. Age (In yrs. last birthday) Sex 1 M M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 0371471973 MD 37 Director 227-11-4474 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20814 5225 POOKS HILL ROAD, #307 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NON-PROFIT OFFICE MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ MAX **ESTHER** permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marken any injury or other traumatic e TELLER HOWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER TELLER/MOTHER 12501 STREAM WOOD LANE, POTOMAC, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD MOGAN ABRAHAM CEM. 6/13/2010 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl for use as t IF FEMALE: . asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 g Unknown 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform page 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 💢 No 1 🔲 Natural 5 Pending 12 2010 Bok PMM within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Route Num City or Town, States 225 75, 15 determined building, etc. (Specify) Home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in the cause of examination and or investigation and Medical (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the P only one) 29c. License number 29d. Date signed (Month, Day, Year) D00428 mp DME 524 Kankesbyr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BREKAR MOOME 31. Date filed (Month, Day, Year) State Registrar

Box 68760

Records,

Division of Vital

10-04488 **Durrane Thaver** 

**Medical Examiner** 

Physician/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day June 13, 2010 1635 hrs Thaver Durrane 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1620 McElderry Street Baltimore

Funeral Director any

Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

П	5. Social Security Number 6. Sex 7. Age (In yrs. last	st birthday)	If Under 1 Year If Under	er 24Hrs. 8. Date o	f Birth(MN	MDD/YYYY) 9. Birt							
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Ì	215-83-3105 1 M 2kF 32	Yrs.		[ ]08/.	12/1	977	<sup>ıntry)</sup> Pak <b>ist</b> an						
ı	Usual Residence of Decedent												
	10a. State 10b. County 10c. City, 1	own or Location	n				10d. Inside City Limits						
	MD NIA	Balti	moro			1 X Yes 2 No							
5	MD NA	Daiti	more										
芨	10e. Street and Number		10f. Zip Code	10g. Ci	0g. Citizen of What Country?								
Ψ	1630 Maridonny Stroot		21205		Pakistan								
끸	1620 McElderry Street												
Ë	11. Marital Status 12. Was Decedent Ever in U.S		Decedent of Hispanic Orig		No-	14. Race - Americ	can Indian, Black,						
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<u>چ</u>	l or Dates:		-24										
핗	15. Decedent's Education (Specify only highest grade completed)		s Usual Occupation (Give st of working life. DO NOT			Kind of Business/Ir							
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희	12th grade 8yrs+	St	udent		Ur	niversit	:y						
Completed by Funeral Director				(a. 5) (8) 5 - 6 - 6 - 6 - 6			-						
7. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)													
Zulfikar Thaver Shehnaaz Thaver													
P 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
-	Dankhan	41 /1	612 0	anial Ch	V-	rachi	Dakistan						
Zakir Thaver-Brother 41/1 612 Commercial St, Karachi, Pak													
		ace of Disposit ematory or othe	ion (Name of cemetery,	Date	20c.	Location - City or	Iown, State						
	T X Durial 2 Cremation 3 Nemovariion state			c /00 /30		- 1- 2	Dalada basa						
ı		jid-Ya		6/20/10	Ka	aracnı,	Pakistan						
- 1	21. Signature of Funeral Service Licensee		me and Address of Facility										
March F/H West 4300 Wabash Ave, Baltimore, Md 21215													
$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval												
	failure. List only one cause on each line.		, 0.				Between Onset and						
	Immediate Cause (Final disease a. Multiple Injuries												
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a												
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뒴	23b, Was decedent pregnant in the		death 3 Ectopic	pregnancy			ay Year						
ä.	past 12 months?  4 Pregnant at time of dea		er (Specify)				,						
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اجَ			ded declaration of the first	-11 Ion 5	id takes ::	tion contails to 4 - 4	he equipped death?						
믭	Part II. Other significant conditions contributing to death but not res	sulting in the un	derlying cause given in Pa		_	use contribute to t	-						
ᅙ				1	Yes 2	✓ No 3 Prob	ably 4 Unknown						
pe				24a. V	las an	24h Were aut	opsy findings available						
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ટી				1 V	es 2	No 1 Ye	s 2 No						
Be Complete	25. Was case referred to medical		26.Place of Death	(Check only one)									
삥	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 E	R/Outpatient	3 DOA Other	Nursing Home 5	Resid	ence 6 🗸 Other:	Scene						
Ě		28b. Time of In	ury 28c. Injury at Work	? 28d. Descr	ibe how in	jury occurred							
5	1 Notural (Month Day Year)	1544 hrs	1 Yes 2 🗸	Subject i	umped	from dorm roo	m (9th floor)						
놡	2 Accident Investigation	, , , , , , , ,	Tes 2	NO									
اق	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City												
Ψį	determined (Specify) Dermitory				n, State) Iderry Str	eet, Baltimore, M	MD.						
ပ္	20a Cortifier												
<u>_</u>	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge												
Medical Certification: To	one) 2 Medical Examiner: On the basis of examination and	d/or investigation	on, in my opinion, death oc	curred at the time, of	ate and pl	ace, and due to the	e cause(s)						
ě	and manner stated.  29b. Signature and title of certifier		29c. License number		29d.	Date signed (Mor	th, Day, Year)						
_	N = 10.0						,						
	/ Y (le you wheele		O.C.M.E.		l Ju	ne 14, 2010							
	10. Name and address of person who completed cause of death (Item 2	(3a)											
İ	Laron Locke MD. Assistant Medical Examiner		Street, Baltimore, M	D 21201									
- 1	Laton Lucke IVID. Assistant IVIEGICAL EXAMINE	THE CHILL	Casca, Dalairioic, IVI										

State

Registrar

31. Date filed (Month

egistrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

tomy vigilant		- For State	ite of Marylane		ficate of	Death			Reg. No	).	
Physician	1/	egistrar I. Decedent's Name (First, Middle						2. Date of De Month	ath Day		3. Time of Death
Medical Examin		Ronny Stev				b. City, Town, or	- Landian of	June 8, 2	2010	c. County of Death	0917 hrs
		ta. Facility Name (if not institution, 10665 Gramercy Place		er)	*	Columbia	Location of	Death		Howard	•
Funeral	1	5. Social Security Number 6	6. Sex 7. A	Age (In yrs. last	birthday)	If Under 1 Yea		_	Birth(MN	//DD/YYYY) 9. Bin Foreig	
Director	-	594-03-0652 Usual Residence of Decedent	1 <b>XM</b> 2 <b>F</b>	30	Yrs.	Months Day	/s Hours	Feb.	18,		untry) Hawaii
any		10a. State 10b. County		10c. City, To	own or Location	on					10d. Inside City Limits
land f show	<u> </u>	Maryland How	ard	Colu	mbia				10- 0	tions of Mines Cour	1 Yes 2 No
the Mary a or 28a- tiffed at	Direct	10e. Street and Number  10665 Gramercy	/ Place, Ap	ot.111		10f. Zip Code 21044			US	itizen of What Coul	ntr <b>y</b> ?
eath with items 23	Funeral Director	11. Marital Status 1 X Never Married 2 Mar	12. Was Decede Armed Force 1 X Yes					? ( Specify Yes or Nouerto Rican, etc.)	lo-	White, etc.	ican Indian, Black,
after d		3 Widowed 4 Divo	rced If Yes, Give Year or Dates:			Yes 2 No				Specify.	ick
hours a	8	15. Decedent's Education (Speci			6a. Decedent during mo	's Usual Occupa ost of working life	ation (Give kir e. DO NOT u	nd of work done se retired)	16b.	Kind of Business/	Industry
036 tthin 72 ne. r than " Iedical	Completed	Elementary/Secondary (0-12)	College (1-4 o		Active	Duty M				.S. Navy	<b>'</b>
21215-003 uld be filed withi Mental Hygiene. marked other th	Be Co	17. Father's Name (First, Middle, L Lawrence Vigile		-				Name (First, Middle Fontaine	, Maide	n Surname)	
Fages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Ann F. Vigilan	ip (Type, Print )		19b. Mailing	Address (Stre	et and Numb	er or Rural Route Ni kton, Vir	<sub>umber,</sub> gini	City or Town, State	e, Zip Code) 4
Baltimore, MD bernit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatingury or other traumatingury.		20a. Method of Disposition  1 XBurial 2 Cremation		cre cre	matory or oth	tion (Name of ce er place) Nation		Date <del>UN. V.</del> 3-5-2010		Location - City or	
Baltimo permit. Page Department o Important: injury or oth	ŀ	4 Donation 5 Other Spe 21 Signature of Funeral Service L	ecify:	R Dow	Cemete ne <sup>22. N</sup>	ame and Addres	s of Facility				Virginia neral Home
Ba perm Imp Imp	Ц	Build Strine	1 - CC050	18	1	171 W.	Maple	Ave.,	/ien	na, Va.	22180
Physician /Medical	Т	2 a. Part Enter the disease, or of failure. List only one cause of	on each line.						rrest, s	hock, or heart	Approximate Interval Between Onset and Death
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68760, certificate be nding physicise as the burit		IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outo	come of pregna		al death 3	Ectopic <sub>i</sub>	oregnancy	2	3d. Date of deliver Month	y Day Year
c.O. Box 687 that the death certific ned by the attending p detached for use as it	ysician/	past 12 months?  1 Yes 2 No 9 Unkr	7	at time of death	-	ner (Specify)					
O. Enat the ed by the etached	by Phy	Part II. Other significant condition	ons contributing to de	ath but not resi	ulting in the u	nderlying cause	given in Part	1. 23e. Did			the cause of death?
ords, P.O. w requires that as been signed be should be deta								'			utopsy findings available
cord law rec	Completed				-			aut	opsy form <u>ed</u>	prior to death?	completion of cause of
tal Rection: The		25. Was case referred to medical	-			26 Plac	e of Death (	1 Yes	2	No 1 🗸 Y	es 2 No
/ital ysician ysician his certi	o Be	examiner?  1 Ves 2 No	Hospital: 1 Inpa	itient 2 E	R/Outpatient		<del></del>	Nursing Home 5	Resi	dence 6 🗸 Othe	r: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detackled in by the funeral director, page 2.	-1	27. Manner of Death	28a. Date of I (Month, Da	njury 2 y,Year)	8b. Time of I	′′ I _′	ury at Work?		e how i	njury occurred	
ivision or Attend after death. Director:	ăt	- La y original	tigation	Finium - At hom	e farm stree	et, factory, office	Yes 2 1		(Stree	and Number or R	ural Route Number, City
Divis	Certification:		not be   286. Flace of mined (Specify)	injury - Action	ie, iaim, stree	st, lactory, office	ballaling, oto.	or Town			
	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of niner:On the basis of e	xamination and	, death occur l/or investigat	red at the time, o	date and place on, death occ	e, and due to the ca urred at the time, da	use(s) te and p	and manner as sta place, and due to the	ted. ne cause(s)
To 1 With To 1	Med	29b Signature and title of certifier	and manner state	ed.			nse number			d. Date signed (Mo	
		tan a.	- Yoll	24-		0.0	.M.E.		Ju	ine 9, 2010	
d		30. Name and address of person Patricia Aronica-Pollak		of death (Item 2		111 Penn 9	Street. Bal	timore, MD 212	201		
√U' Sta	ate	31. Date filed (Month, Day, Year)		trar's Signature							
Regist		MAI 4 2 6	2040	A		W. A.					

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ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
AMEND ITEM#19a, perFH, 6904, 6722, 2010, WS Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Shirley Maxine Vogts <u>11:47</u> a <sup>M</sup> June 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex Age (In vrs. last birthday) Country) Montana **Funeral** Hours (Month, Day, Year 6/16/1926 1 M 2 F Days Min. 83 389-20-8274 Yrs Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location Silver Spring permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director MD Montgomery 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20904 Funeral 2304 Musgrove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Schwallenburg Max Meyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura 4362 Aitcheson Rd. Beltsville, MD 20705 Jean Sanchez, daughter <del>Lura</del> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2XXCremation 3 🗀 Removal from State Chesapeake Crematory 6/11/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service sicens 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. M01539 933 Gist Ave. Silver Spring, MD 20910 Many 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Brain Abscess disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 🖔 nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? To the Hospital or Attending renystoration within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director, page 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence MY Other (Specify) Hospice 24X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 🔯 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Diane Ruckert, CRNP; 601 Muncaster Mill Rd. Rockville, MD20855

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 1 5 2010

Barke

32. Register's Signature

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) June 13, 2010 Year Physician 9:34P M ROBERT AUSTIN VAN RIPER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Ruxton Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 18, 1921) Birthplace (State or Foreign Country)
 VOYK 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral XXX**M 2□ F 072-14-4550 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, Ite Madical Exacting mast be recitived at 1¥XYes 2 □ No **Funeral Director** Maryland None Baltimore 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 21218 USA 4100 North Charles Street 12. Was Decedent Ever in U.S.
Acreed Forces?
1 ∰Ves 2 □ No WWII
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes XX No White Baltimore, Maryland 21215-0036 Specify: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Executive Advertising 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys LaFetra Brownell Austin Millard Van Riper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7106 Wardman Road Baltimore, Maryland 21212 Alexandra Van Riper Bulkley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 XX remation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 06/15/2010 Baltimore, Maryland GreenMount Crematory □Donation 5 □ Other (Specify) gnature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementin Sterge **Physician** End /Medical Due to (or as a consequence of) **Examiner** Hypertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Physician/Medical Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No certificate 2 No 1 🗌 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mann of Death 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 1 Tyes 2 No 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 WD USIEV J- HIRTARA W) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 5 2010▶

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Ttems 7,8 per fh g904 6-22-10 vt State of Maryland / Department of Health and Mental Hygiene 860 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 12:28 AM Vankleeck **Physician** 13 DA 2010 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University of Maryland Medical Center Baltimore 8. Date of Birth Septih Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2**X** F 214-72-0764 St. Paul, MN Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Forest Hill Maryland Harford 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō United States 21050 323 Bynum Road 23a Funeral 14. Race - American Indian. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ∐Yes 2 🛣No White Specify Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Earth Science Teacher Aberdeen High School 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorraine Weeks Frederick Bromhal ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any Injury or other traun once. 323 Bynum Road Forest Hill, Maryland 21050 Alvah Van Kleeck (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Evans Funeral Chapel Bel Air 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State June 17, 2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel & Cremation Se
3 Newport Drive Forest Hill, Maryl

23a. Part 1. Bue, the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death Physician Massive ulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) been signed by the should be detached 9 Milinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐Yes 2 No 1 □Yes 2 No ospital or Attending Physician: The hours after death.

uneral Director: After this certificate by filled in by the funeral director, par 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 1841427077 June 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 MD Baltimore, Green St. Yazid 22 ulmalky 31. Date filed (Month, Day, Year) 32. Registra s Signature State 5 2010 > Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Emma M. Valentine **Physician** June 13, 2010 1:30 A. /Medical 4c. County of Death Cecil County 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Laurel Woods Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** September 26, 1916 Months Days Hours Min. Maryland 1 □ M 2**X** F 217-01-7634 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rediffed at once. 10a. State 10b. County 10c. City, Town or Location Baltimore Cockeysville Maryland 1 ☐ Yes 2 TXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21030 10535 York Road Apt. 316 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □ Yes 2 🗰 No Specify: <u>م</u> Specify. 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Broker Cashiet 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Walters Frank J. Snyder ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
329 Sandown Park Court Belair Maryland 21015 19a. Informant's Name/Relationship (Type. Print) Jeffrey D. Krichton/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2010 Baltimore Maryland 22. Name and Address of Facility Leonard J., Ruck, Inc 5305 Harford Road B 21. Signature of Funeral Service License Baltimore Mayrland 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician 01/01/10 YES disease or condition resulting in death) /Medical Due to ( r as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit ΡÌ vator Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 🗌 Yes 2 No 3 Probably 4XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

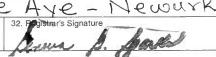
1 ☐ Yes 2 ☐ No 24a. Was an CÌ autopsy After this certificate Dementi 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural n 24 hours at er death. le Funeral Director Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated.

State Registrar 31. Date filed (Month; Day,

29b. Signature and title of certifier

30. Name and address of perso



no completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Van Hoose, Richard Lee June June 10ay Physician/ 2010 3:02 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Dunda1k 8339 Bear Creek Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. | 6. 1935 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 1**X**XM 2 □ F Kentucky 75 213-30-5400 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Markinal Example. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Dundalk Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 8339 Bear Creek Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒No Black, White, etc. ۵ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Industry Truck Driver 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Wood Irvin Van Hoose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Van Hoose, Jr. 1335 Old Westminster Pike Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/12/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp Signature of Fu Servi 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Dundalk. Maryland Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dise Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ HEPATOCELLUL CARCINOMA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to jor as a consuluence of cause. Enter Underlying Cause (Disease or iinjury Exami s been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy After this certificate has funeral director, page 2 s death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HEMATOLOGIST, ONCOLDGIST D-51555 06/10 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10v State

FRANKLIN SOUARE DRIVE # 2200, BALTIMORE MD 21237 9103 31. Date filed (Month; Day, Year) Registrar

AUNG

32. Refistrar's Signature

10-04260 Diandre Eugene	\A/ii	Please Type or Print in Black Indelible Ink.				gibl	e.	8604					
Dianule Eugene		son, Jr State of Maryland / Department of Hea  1- For State Certificate of Dea  Registrar		iu ivientai n		Reg. No.		1-0004					
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)  DiAndre Eugene Wilson, Jr.			2. Date of Dea Month June 4, 2	ath Day	Year	3. Time of Death 1353 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City Upper Chesapeake Bel		r Location of Deat	h		c. County of Deat Harford	1					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur	nder 1 Ye				/DD/YYYY) 9. Bit						
Director		218-71-7929 1XM 2F 5 Yrs. Mon	iths Day	ys Hours Mir	Feb.	28,	2005 Foreign	puntry) MD					
v any		10a. State 10b. County 10c. City, Town or Location					<del></del>	10d. Inside City Limits					
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Baltimore, MD 21215-0036  Bernit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	eral			ispanic Origin? ( S		0-		ican Indian, Black,					
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36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired)  Child										
5-0036 fled within 7. Hygiene. I other than	Som	17. Father's Name (First, Middle, Last)	CIII	18.Mother's Name	e (First, Middle,	Maider	Surname)	<del></del>					
121; d be fil fental F arked	Be	DiAndre E. Wilson, Sr.			erly A			7.0.1.04.04.0					
MD 21 d 2 should Ith and Me n 27 is ma aumatic ev	입							, zip <sup>Code)</sup> 21040 dgewood , MD					
re, h	Ì	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (No crematory or other place)	ame of ce		Date	20c.	Location - City or	City or Town, State					
Baltimore, permit Pages la Department of He Important: If ite		4 Donation 5 Other Specify: Greenmount Cemetery 6/16/10 Baltimore,											
Balt permit Departi Impori		21. Signature of Funeral Service Licensee 22. Name an	d Addres	<sup>ss of Facility</sup> Cha lair Roa	atman-	Har	ris Fur	neral Home					
Physician	┪	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying	g, such as cardiac	or respiratory ar	rest, sh	ock, or heart	21206 Approximate Interval Between Onset and					
/M di al Examiner	ı	Immediate Cause (Final disease a. Viral Syndrome with Myo	card	litis				Death					
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.											
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		-			<del>.</del>						
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cords, P.O. Box 68760, law requires that the death certificate be ex has been signed by the attending physician 2 frould be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Others (So		Ectopic pregna	ancy	23	d. Date of deliver Month	y Day <b>Y</b> ear					
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Vital Revision: The bis certificate director, page	BB	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Plac	e of Death (Check		\ <b>n</b> = -: d	ence 6 Othe						
n of Vi ding Physi After this funeral dir	٦ إ	27. Manner of Death 28a Date of Injury (Month, Day,Year) 28b. Time of Injury		ury at Work?	ng Home 5			<del></del>					
tendir tendir death. stor: A	atio	1 X Natural 5 Pending 2 Accident Investigation	1	Yes 2 No				2002 123423					
Division of Vital Records, P.O. ral or attending Physician: The law requires that the star death.  al Director: After this certificate has been signed by the funeral director, page 2, should be detact	ertification:	3 Suicide 6 Could not be determined (Specify) Suicide (Specify)	y, office I	building, etc.	28f. Location ( or Town, \$		and Number or Ru	ral Route Number, City					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the control of the control one)  Wedical Examiner: On the basis of examination and/or investigation, in many one)											
To wit	Me	and manner stated.  29b. Signature and title of certifier  25	c. Licens	se number				ate signed (Month, Day, Year)					
		Mlu Brasn y MD	O.C.	.M.E.		Jun	e 5, 2010						
		<ol> <li>Name and address of person who confipleted cause of death (Item 23a)</li> <li>Melissa Brassell, MD Assistant Medical Examiner 111 Penn S</li> </ol>	treet, I	Baltimore, MD	21201								
	ate	31. Date filed (Month) Day, Year) = 32. Registar's Signature	1.1										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\overset{\text{Day}}{2} \underline{010}$ Physician/ JUNE 10 MAURICE ANDRE WALKER 1:08a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE BALTIMORE TOWSON Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 - F Hours 1-12-1969 PENNA **Director** 41 166-56-4643 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 TyYes 2 No YORK PA. YORK 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 177 LINCOLN ST. 17401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, "natural", or þ 1 X Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) -12-LABORER -0-STAUFFERS COOKIES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DEBRA WALKER GEORGE McEACHERN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAE RANDOLPH (AUNT) OVERSTREET SUNRISE BEACH TEXAS 78643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 🗌 Burial X Gremation 3 Removal from State METRO CREMATORY 6-11-2010 BALTIMORE, MARYLAND Other (Specify) 4 Dona of Fuerral Service Licensia JONATHAN HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatur D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death k, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ anore disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown Yes 1 Yes 2 L 9 Unknown detached been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe 2 🗆 No 1 Yes Division of Vital Be the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 2 No ၉ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Mapner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 🕉 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29h. Sia ure and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print) CHARLESST. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 14, 2010 7:50 AM **Physician** Margaret Ann Warren /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Rosedale Manor Care Rossville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months 1 □ M 2 🗓 F 78 Maryland 212-30-9373 August 17,1931 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar investigate an once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Funeral Director Rosedale Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21237 6600 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Margaret Combs UNK. Benolis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1405 Federal Garth Abingdon, Maryland 21009 Son Craig Warren, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 06/15/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 roma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. physician the ast IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 Other (specify) o the 9 Hinknown been signed by should be detack σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page performe 1 ☐ Yes 2 ☑ No certificate 2 No 1 TYes or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after usa...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

ure and title of certifier

nd address of person who

29b. Sign

31. Date filed (Month,

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Witham Words Road.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 10 Physician/ mmett 3:00AM ine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8207 Bullneck Baltimore Dundalk Maniland If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth April (2 193) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Director 213.36.0128 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD Baltimore Dundalk 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8207 Bullneck Road 21222 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. pernit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CAtherine George Thomas Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8012 Stratman Road, Dundalk, MD 21222 Ann Watts/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State njury or 1 
Burial 2 Cremation 3 
Removal from State Beltsville, MD 06.15.10 4 ☐ Donation 5 ☐ Other (Specify) Chespeake Crem. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA MO1443 Pastures Dr. BAlto., MD21286 8717 Green 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ears anemia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): syndrome myelodys lash c or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury and that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 No detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 4 Nursing Home မ 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ! only one) 29b. Signature and title of oer D0057658 14,2010 Stasia S. Reynolds MD 4940 Eastern Arenue Ruymolds 31. Date filed (Month, Day, 32 Registrar's Signature

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State

Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Pel - Air Matorial 20c. Location - City or Town, State June 21. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel - Air, Maryland 2010 5 ☐ Other (Specify) 4 ☐ Donation **Cardens** 22. Name and Address of Facility Evans Funeral Chaptel & Cremation Services Bel — Air 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sales on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAUS Physician bneumonia /Medical Due to (or s a consequence of): Examiner rentilater dependent toillure months Respiraten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death. obstructive 4 445 Chronic physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hypertension Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diaheies mellitus, anemia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an as S autopsy performed? 1 □ Yes 2 V No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manger of Death 1 Natural 5 Pending investigation within 24 hours after use....

To the Funeral Director: After the function of 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State Registrar KDESAIND

31. Date filed (Month, Day, Year)

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maidenthoise lane 302 Balkimore MD x 1228

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

716

618/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:45 P M Jane A. Wisseman 2010 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Broadmead Cockeysville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) June 11 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1<u>921</u> 1 M 2 Hours Director 89 449-34-9636 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🙀 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13801 York Road 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. County School <u>ibrarian</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Robert W. Abrahamson Mertle Braden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Cedar Knoll Rd., Cockeysville, MD 21030 Mary W. Donahue/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6/19/10 cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of File of Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. O W. Padonia Rd., Timonium, MD 21093 Michael ! Flagi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day 1 ☐ Yes ∠ ... 9 ☐ Unknown should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an this certificate has page 2 autonsv death? 2 No 1 Yes 2 No ☐ Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2/1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be To the Hospital or Atte within 24 hours after der To the Funeral Directol completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura 123627 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3346 Paper Mill Rd., Suite X, Phoenix, MD 21131 Francis Sanzaro, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 2010 Sharon Uvee Wheeler 3:26 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8905 Chesapeake Avenue Baltimore Co. Edgemere If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, **Funeral** (Month, Day, Year) an 24, 1948 1 □ M 2 🗓 F Months Hours Min. Mary land 62 Jan\_ Director 214-50-6130 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 72 hours after death with 8905 Chesapeake Avenue United States 21219 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married 1 Yes 2 XNo Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan Specify: Completed 3 Widowed 4 Divorced White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Franklin Sollars Uvee Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 Mr. Robert J. Wheeler (Husband 8905 Chesapeake Ave. Edgemere, Maryland Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Hilltop Service Corp. 6/12/2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Free Service Lice 32. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons. t and Death Immediate Cause (Final Physician/ site spina disease or condition resulting in death) **Medical** Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Year Pregnant at time of death n signed by the a 9 Unknown 9 Unknown P.O. Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours a ler death.

To the Funeral Director: After this certificate has I completed filled in by the 'uneral director, page 2 s autopsy director, page 2 performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 🗌 Inpatient 2 🗍 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5  $\square$  Pending Natural 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DHILLEC Kinester Mil Dire 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) haltwore

State Registrar 31. Date filed (Month, Day

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28d, e. f., per MF g904 6/30/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Wright 615 Audrey Medical 4a. Facility Name (if net institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Balt of Mary and Medical Cota 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Und If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min Mary Land 1 M 2 F 81 Director 217-24-4757 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Important: If item 27 is marked other than "natural", or items 23a or 28a-f shc any injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No Dunda1k Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 885 Jaydee Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XX No
If Yes, Give Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: 3X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Grace Maine James W. Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2315 Edwards Lane Bel Air, Maryland 21015 Jeraldine K. Jenkins(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem, Park 6/16/2010 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between CENTRESITON APPROPRIET MEDICAL ECONOMICS Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Tramati Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by talue 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown safter death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? Arrhy Mmic ardiac 24a. Was an page 2 autopsy performed Yes 2 🖼 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 1 ✓Yes 2 □ No 5 □ Residence 6 Ø Other (Specify) Street မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28d Describe how injury occurred subject driver of a car fell out of a car after colliding with 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Injury 1500 5 Pending Natural work? 1 ☐ Yes 2 ☑ No Accident Accident 6/11/10 Investigation 28f. Location (Street and Number of The Pouls Tumber City or Town, State) 718 Nursery Rd
Linthicum, MD 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined street 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the second the second to 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number 6/12/10 (P4) OT Ø 1766 1 and address of person who completed cause of death (Item 23a) (Type, Print) 17403); 22 S. Greene St. Bettimore, MD 21201 (1534 Fourth York 31. Date filed (Month, Day, Year) 32. Registi State all Registrar

		1 - For State Registrar	State of Maryla		artmen rtificat			and M		giene Reg. No.	010	186	13
		Decedent's Name (First, Middle, Last)							2. Date of De	Day	Y <i>e</i> ar_	3. Time of D	
Physic /Med		Latashia Wallace							May	31	2010	10:17	PM
Exami		4a. Facility Name (If not institution, give s		<b>.</b>		Town, or L		of Death			ounty of Death nne Aru	ndo1	
		Bayridge Health &			If Under	napoli	LS If Under:	24 Hrs	8. Date of Bir	th.			Foreign
Funeral		5. Social Security Number 6. Sex 1219-88-0770		rrs. last birthday) 44 Yrs.	Months	Days	Hours	Min.	Aug 8,	1965	Mary	olace (State or ntry) 'Land	r orongin
Director		Usual Residence of Decedent			1						12		
rland ow		10a. State 10b. County		City, Town or Lo								10d. Inside City	
Man,	ţō	MD Anne Ar	unde1	Annapo1	is					_		1 🗌 Yes	2 <u>1</u> No
h the	Director	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
th wit	a	71 Heritage Cour	t			L401				USA			
dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Dece If Yes, spe	dent of His	panic Ori , Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	D- 14.	Race - Ameri Black, White		
or It	y Fu	1 Never Married 2 Married	1 ∐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes	2 <b>√</b> No	Specify:			S	pecify: blac	ck	
ure!',	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dace	edent's Usu	al Occupat	ion			16h Kind	of Business/Ir	ndustry	
n 72 "nat	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	kind of wo	ork done du ise retired)	iring mos	t of work	ing			,	
withi ene. than	Щ	Elementary/Secondary (0-12)	Colleg <i>e</i> (1-4or 5+)	ca	shier					K-	Mart		
be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "naturel", or Items 23a or 28e-f show event, the Madical Examinar mast te motified at	a	17. Father's Name (First, Middle, Last)					18. Mothe	ers Name	e (First, Middle	, Maiden Su	ітате)		
Mental Neutal rked	ToB	George Hill					Oph	elia	Hunter	:			
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "naturel; or Items 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (Ty									own, State, Zi		
and 2 ealth a m 27 is		Mona Johnson/cou					Cour				ryland		
of He		20a. Method of Disposition  1 Burial 2 Cremation 3 P		b. Place of Disp cemetery, cre	osition (Na matory or	me of other place	)		Dat <i>e</i>	20c. Loca	ition - City or T	own, State	
Pag ment ant: I		4 □ Donation St Other (Specify)	in state	/			1						
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licens RONald S	ade, parecy	or 3							altimo:	re Stre	et
70 = e c		23a. Part1. Exter the disease, or/compl	instings that caused the	teath. Do not er	Balt	<u>imore</u>	, Ma	ryla:	nd 2120	) <u> </u>		Approximate	
		shock, or beart failure. List only of	ne cause on each line.									Interval Betw Onset and D	
Physiciar /Medica		disease or condition resulting in death)	Due to (or as a cor	JE E	>	1100		0>					
Examine			HY	PERTE	> n	mon							
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certificate be executed adding physicien and use as the burial-transit	lcal	•	d										
wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pro	egnancy						23	d. Date of deli	verv	
death cer	ian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	□Ectopic					23	Month		ear ear
he de	ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	9□ Unknown	or doubt.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
requires that the een signed by th hould be detache	y P	Part II. Other significant conditions co	ntributing to death but no	t resulting in the	underlying	cause give	n in Part	l.	23e. Did	tobacco use	e contribute to	the cause of d	eath?
w requires been sign should be	od by								10	]Yes 2□	No 3□Pr	obably 4	Inknown
law rec as bee	lete								24a. Wa	s an opsy	24b. Were au	topsy findings a	available
0 5 5	Completed								per 1 ☐ Yes	formed?	death?	2□ No	
iclan: Th certificate rector, pag	Φ	25. Was case referred to medical					26. Plac	e of Dea	th (Check only				
· ·	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1   Inpatient	2 ER/Outpati	ent 3 🗆 🖸		4 14 N	lursing H			Other (Spec	cify)	
<u>a</u> = <u>a</u>	ü	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time Injury		28c. Injury Work			28d. Describe	how injury	occurred		
r Attending Phy ter death. irector: After this by the funeral of	catl	2 Accident investigation 3 Suicide 6 Could not be		<u> </u>	M		Yes 2□	]No	29f Location	(Street and	Number or Ri	<i>ıral Route Nu</i> m	ber
	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	street, racto	лу, опісе				own, State)			
pita ours illed			vsician: To the best of my	y knowledge, de	ath occurre	d at the tim	ne, date a	and place	, and due to th	e cause(s) a	and manner as	stated.	
To the Hos within 24 hd To the Fun completely	Medical	(Check only 2 Medical Exam	inar: On the basis of exa and manner stated.	mination and/or	investigatio	on, in my op	oinion, de	ath occu	rred at the tim	e, date and p	place, and due	to the cause(s	.)
To the within 2 To the complet	Me	29b. Signature and title of certifier		0	2	9c. License	number			29d. Date	signed (Mont	h Day, Year)	
)		Inra	M -	¥ .		05	4	513		L	> 2	110	
		30. Name and address of person who d	ompleted cause of death	(Item 23a) (Typ	e, Print)		4	0.2	C	1/4	14 CS	711 2	10
		IN I UL DRVI	705	> UM	EVK	045	_1	NK	U	NO	1101	14 0	107
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature A	L	N. S.						7	

DHMH 17 Rev 1/2001

10-04059
Timothy Wilkes

imothy Wilkes		1- For State Registrar	State	e of Maryla		artment ertificate			d Me	ntal H	ygiene	Reg.	20	10	8611
Physici		Decedent's Name (First, M	iddle,La	ast)					-		2. Date of Month	Death			3. Time of Death
Medical Exami	ner	Timothy Wilk									May 27	, 201			1939 hrs
		4a. Facility Name (if not instit			mber)			City, Town, or	Location	n of Death	1		4c. County o		
		Peninsula Regional						Salisbury	1		Ta a		Wicomic		
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ith the Maryland 23a or 28a-f sho notified at once.	Director		1 - 1	NT1- D	1									at oour	
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eath w	Funeral	1 Never Married 2	Marrie	d Armed Fo	rces?			s, specify Cubar							air indian, black,
ter de		3 Widowed 4 K	Divorce	1 Yes ed If Yes, Give Yea	2 🔀 No	1	¬ <sub>Y</sub>	res 2 X No	specif	fy:			Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: black  3b. Kind of Business/Industryunk  den Surname)  r, City or Town, State, Zip Code)  na 27801  Oc. Location - City or Town, State  W. Baltimore Street  Shock, or heart Approximate Interv Between Onset an Death  23d. Date of delivery  Month Day Year		
urs af tural	d b	15. Decedent's Education (S		or Dates:		16a. Dece	dent's	Usual Occupat	tion (Giv	e kind of v		nk 16			
2 - 12	ete	Elementary/Secondary (0-	12)	College (1	-4 or 5+)	during	g mos	at of working life	. DO NC	)T use reti	red)				
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21215-0036 vuld be filed within 7 Mental Hygiene, marked other than	Be										Vilkes				
D 2 should and M 7 is m	ျ	19a. Informant's Name/Relation													Zip Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Crema	tion 3	Removal fro		crematory or			inetery,		Date		oc. Location -	City Of	own, state
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the br				oonang to	dodan Parmor	rooding in a	io uni	2011 <b>y</b> 111g 022000 g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Gre i.		Yes 2		_	ably 4 V Unknown
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Division of Vital Records, rate or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should the complex of the control of the control of the funeral director.	ם											utopsy erform <u>e</u> e	pr		empletion of cause of
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Division  To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only		cian: To the best er:On the basis o	f examination a										
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	ŀ	30. Name and address of pers	son who	completed cause	e of death (Iter	m 23a)									
		Laron Locke MD.		stant Medical	•	,	nn S	Street, Baltin	nore, l	MD 212	01				
St	ate	31. Date filed (Month, Day, Ye.	ar)	32. R	gistrar's Signat	ture									
Regist		44 0 0 0 4	w 00	40 6		1. 1	as	Carried States							

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year John Weissinger : 15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral . Age (In yrs. last birthday) 8. Date of Birth 1 XM 2 | F 9 / 29 / 1 9 3 4 159-30-8617 75 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Frederick must be notified MD Frederick X Yes 2 □ No 10f. Zip Code 21703 10g. Citizen of What Country? 10e. Street and Numbe 4214 Lime Klin Road 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner 0. Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 2X No 1 ☐ Yes 2 😾 No Specify: Specify: White "natural", 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 10 Grounds Keeper Cemetery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H, Important: If item 27 is marked oth any injury or other traumatic even any injury or other traumatic even once. Francis John Weissinger Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim John Weissinger/Son 149 North Main St., 1st floor, Red Lion, PA 17356 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 6/12/2010 4 Donation 5 Other (Specify) Woodbine, MD Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Maxhorn ainta 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician, Carcinoma Mandibylar disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying Due to (or as a consequence of). The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 V No Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) + hospice Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea... ral Director; Afte 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 175 Rajapanse M'1) 6/10/10 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28-35 Smith Av. 5-235, Baltimore, MD. 21209. N.S. RajapaKSE, MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 Year Doris K. Wilson **Physician** 13, June 8:10a M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Rosville Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 / 24 / 1922 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 214-18-3670 1 ☐ M 2 ☐ **X**F 87 MD Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Precies Exercises must be collided at Baltimore MD 1X Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or USA 9403 Philadelphia Road 21237 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 9 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgie Brannock Henry F. Seitz ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9403 Philadelphia Rd. Baltimore, MD Daughter Eileen Johnson / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ol 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorota Marsahll 22. Name and Address of Facility Maryland Cremation Services Marshall Box 1413, Baltimore, MD 21203 PO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 🗷 No ned by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate 1 □ Yes 2 □ MG 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 27, Mann Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 atural n 24 hours after death.

le Funeral Director; Af 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check or one) and manner stated. within 24 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 29b. Signatu

5√ State

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of perso

31. Date filed (Month, Day,

strar's Signature

words frond MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:57A Susan Yobst Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death wicomic 14050,00 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Jan 11, 1942 1 M 2 K F Months Min. Pennsylvania Yrs 68 Director 577-58-3231 Usual Residence of Decedent Show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 212 Creekside Drive 21804 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by SUSON YOOSH Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nurse healthcare Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walter Mann Male Ruth S. Spangenberg permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Yobst/son 9255 Hickory Mill Road; Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 Oher (Specify) Signatur of Funeral Service Licensee Ronald S. 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CARCINOWA Puysician. MALICE NANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE signed by the attendin 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 3 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICZ ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Exitiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Control of the cause of the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. only one) 29b. Signature and the of certifier D0058 410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 a Hungan SAGBUN WAN 80 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Dhuninin		Amend #2, per M  For Amend 20a-c, Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate of	Death		eath June 6, 20	10		
Physicia		Marian Yorkman					Month.	21 19 <sup>Yea</sup>	3. Time of Death 11:35 PM		
Medica Examine		4a. Facility Name (if not institution, give si	treet and number)		4b. City, Town,	or Location of Dea	th	4c. County of De			
		Upper Chesapeake			Bel A			Harfor			
Funeral Orector		5. Social Security Number 6. Sex 224–38–4728	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			21°, 1933	Birthplace (State or Foreign Virginia		
nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	_	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	eation				10d. Inside City Limits		
iffied	ecto	MD Harford		erdeen					1 ☐ Yes 2🛣 No		
st be no	Funeral Director	10e. Street and Number 700 West Belair	Avenue; Apt 2	03	10f. Zip Code 21001			10g. Citizen of What	Citizen of What Country?		
		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes, 21 No If Yes, Give Year or Dates.	If	Vas Decedent of Yes, specify Cu	Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or No to Rican, etc.)	Black, WI	14. Race - American Indian, Black, White, etc. Specify: black		
	Completed by	15. Decedent's Ed. (Specify only highest grad Elementary/Seconday (0-12)	cation e completed) College (1-4 or 5+)	(Give k	ent's Usual Occi aind of work done ONOT use retire	e during most of wo	orking	16b. Kind of Busines			
	a	17. Father's Name (First, Middle, Last)  James Henry	2	LIEN		18. Mother's Na		e, Maiden Surname)			
umat		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Stree	et and Number or R	ural Route Numb	er, City or Town, State,	Zip Code)		
		Margaret Brooks/	sister	520	0 Daybr	ooks Apt	157; Ba	ltimore, Ma	aryland 21237		
		20a. Method of Disposition  1	Removal from State	emetery, crem	sition (Name of natory or other pi <b>metery</b>	6/2/	Date /2010 _	20c. Location - City  Aberdeen,			
any injury or other trai		21. Signatur of Funeral Sept a License		22	. Name and Add State Aberdee	ress of Facility Ta	rring Ca	orgo FH 51 West Bald	timore Street		
10 0		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death		44	WAY:	and <del>212</del>	<del>1</del>	Approximate Interval Between		
cian/ dical niner	9 49	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ence of):	Lun	g Ca	ncer		Onset and Death		
	ē	Sequentially list conditions,	Due to for as a consequ								
al-transit	Examiner	or any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence).								
ior use as the bunal-transit	edical		d								
	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnal 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 🗌	Ectopic pregna Other (specify)			23d. Date of Month	delivery Day Year		
	≥	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.		tobacco use contribute	to the cause of death?		
	Completed						24a. Wa	s an 24b. Were	autopsy findings available		
age 2	E I						per	formed? death	to completion of cause of ? Yes 20 No		
		25. Was case referred to medical examiner?				Place of Death (Ch		10			
al dire	မ	1 🗆 Yes 2 🗐 Vo	ospital: Inpatient 2 🗆		t 3 L DOA			sidence 6 Other (Sp	pecify)		
e funera	icate:	27. Manner of Death  1 Action 1 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inj wo M 1	ury at ork? □ Yes 2 □ No	28d. Describe	how injury occurred			
[	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office	9		(Street and Number or own, State)	Rural Route Number,		
led in t	ا <u>ۍ</u>	29a. Certifier Certifying Physic	cian: To the best of my knowler: On the basis of examination	and/or invest	igation, in my opi	nion, death occurred	d at the time, date	and place, and due to the	ne cause(s) and manner stated.		
oleted filled in b	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	Practioner: To the best of my	rknowledαe. d	leath occurred at	the time, date and t					
completed lilled In C	Medical	(Check only one) 3 Certifying Nurse  29b. Signature and title of certifier	Practioner: To the best of my	knowledge, d	29c. Licer	nse number		29d. Date signed (Mo	nth, Day, Year)		
	Medical		Practioner: To the best of my	rknowledge, d	29c. Licer	1 6 0 7 6 8	4	29d. Date signed (Mo	nth, Day, Year)		

			For State Registrar		State	of Mary	yland /		artment of h tificate of			lental Hy	gien Reg. N	711	0	188	519
			Decedent's Name	(First, Middle, L	ast)							2. Date of De	ath			3. Time o	f Death
	Physici /Medio		Lewis H	[ ]	Burgess							June	3		ar )	4:35	A M
	Examin	er	4a. Facility Name (If	1		,			4b. City, Town, o		n of Death		4	c. County of I			
	Former		Oakland 5. Social Security Nu		& Rehab		ter In yrs. last b	oirthday)	Oaklan		er 24 Hrs.	8. Date of Bi	rth	Garre 9.		ace (State	or Foreign
	Funeral Director		216-01-48		1 <b>½</b> M 2□ F	93	,	Yrs.	Months Days	Hours	s Min.	8. Date of Bi (Month, D 11/24/	ay, Year 1916	(r) V	Count I <b>V</b>	ry)	
	p >		Usual Residence of I			1 40	Oc. City, To		- atio	-					110	d. Inside C	ity Limite
	f show	ō	MD	10b. County	4.4.		0ak1		callon						10		2 No
	the N	Director	10e. Street and Num	Garre	LL		Uakı	and	10f. Zip Code				10g. C	Citizen of Wha	t Count	ry?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner rust be notified at		706 E. A1	der St.					21550					USA			
	ems	Funeral	11. Marital Status		12. Was Dec	cedent Eve	r in U.S.	13. V	Vas Decedent of F f Yes, specify Cub	Hispanic an, Mexic	Origin? (Spe	ecify Yes or Ne Rican, etc.)	)-	14. Race Black, V			
36	s afte	by Fu	1 ☐ Never Marrie 3 🛛 Widowed 4		1 ∐Yes If Yes, G	2 ሺ∭No ìive			□Yes 2X No					Specify:			
21215-0036	thour aftural	led k		15. Decedent's E	Year or I	Dates.	16	a. Deced	fent's Usual Occup	oation			16b.	Kind of Busin	Wh: ess/Indi		
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	ed wit ygjen ygjen her th	Completed	6					Mi	ner	1			<u> </u>	Coal			
Maryland	tal d d	Be	17. Father's Name (F		•							(First, Middle Mathews		en Surname)			
Ž	2 should I and Men is marke aumatic	은	19a. Informant's Nar				19	h Mailin	g Address (Street	L				or Town. Sta	ite. Zip i	Code)	
	and 2 s ealth ar n 27 is her trau		Eugene E.	,		her			0, Box 2				-	26833	,	,	
č,	of E		20a. Method of Dispo	osition			20b. Place cemet	of Dispos	sition (Name of natory or other pla	ce)	D	ate	20c. l	Location - Cit	y or Tov	vn, State	
Ĕ	thent of tant, If ite		1 □ Burial 2 🕅 4 □ Donation			i State		e11i	F.H. PA			4/2010	Cr	esapto	wn,	MD	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Fun					22	Name and Address David A 21 N. S	ss of Fac	rdock	Funera	1 H	ome, P	.A.		
			23a. Part 1. Enter the shock, or hear	e disease, or cor			e death. Do	o not ente	er the mode of dyi	ng, such	as cardiac c	or respiratory	arrest,	MD 21.		Approxima	te
	Physician		Immediate Cause (F disease or condition	inal					tic C					Disa		Interval Be Onset and	Death
	/Medical		resulting in death)	•			onsequence				-w 7	0 - 32 -				7	~
	Examiner	Ļ	Sequentially list cond	ditions,	b										-		
	ted nsit	nine	cause. Enter Underl	ying Tiury	Utan to	(OF 88-9:0)	опяндинати	a-citys									
,	execu n and ial-tra	Examiner	that initiated events resulting in death) La	ast	c Due to	(or as a co	onsequence	e of):							+		
8/60,	icate be executed physician and the burial-transit	dical			d												
ט	ertifica ding pl		IF FEMALE:		00 //												
Ř	death certif e attending d for use as	cian	23b. Was decedent in the past 12 m	nonths?		birth 2	pregnancy I Fetal dea ne of death		Ectopic pregnand Other (specify) _	Э			Ì	23d. Date o Month		ry Day	Year
Ċ	the d	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	9 ☐ Unk		no or doutin		Totalor (Specify)								
λ, J.	w requires that the death certifice been signed by the attending I should be detached for use as	by P	Part II. Other signific						nderlying cause giv	en in Pa	rt I.	23e. Did	tobacco	use contribu	te to the	e cause of	death?
ecord	equire		12	mentia	- De	.2 he	ine	v (	<del></del>			1 🗆	Yes	2 10 3	Proba	ably 4□	Unknown
ပ္သ	has be	Completed										24a. Was	psy	prio	r to com	sy findings	available cause of
īa I	n: The ficate h r, page							·				1 □ Yes	ormed?	¶o dea 1 □	Yes	2 □No	
<b>=</b>	ding Physician: The law h. After this certificate has funeral director, page 2 s	o Be	25. Was case referre examiner?		Hospital:	Innationt	2 □ EB/0	Outpation	t 3 DOA Oth			n <i>(Check only</i> me 5 ☐ Res		6 □ Othor	Cassifu		
	g Phy ter this neral c	n: To	27. Manner of Death		28a. Date		28b	. Time of Injury		ry at		28d. Describe			<i>эреспу</i>	7	
200	Attending r death. ector: After by the fune	atio	1 Natural 2 Accident	5 Pending investigation	on .	nur, Day, re	Sai)	ii ijur y		Yes 2	□No						
UIVISION	l or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not I	28e. Place	e of Injury ding, etc. (	- At home, Specify)	farm, stre	eet, factory, office		1	28f. Location City or To	Street a wn, Sta	a <i>nd Numb</i> er ( ate)	or Rural	Route Nui	nber,
_	ppital ours a neral C		29a. Certifier	Certifying P	hysician: To the	e hest of n	nv knowled	ge death	n occurred at the t	ime date	and place	and due to the	e cause	(s) and mann	er as st	ated.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 one)	Medical Exa	miner: On the I	basis of ex nner stated	amination a	and/or inv	vestigation, in my	opinion, o	death occurr	ed at the time	, date a	ind place, and	due to	the cause(	s)
	within com	Ž	29b. Signature and ti	tle of certifier					29c. Licens	se numbe	1-4		29d. D	Date signed (M			
			<b>P</b>	,					13	سعب	147		6	13/2	sti	ď	
		2	30. Name and address						orint) s Drive,	0ak	land.	MD 215	50				
Ė	Sta	,	31. Date filed (Month			Registrar's	Signature							-			
	Registra	ar	JU	n - 4 ZU	IU A	ha	1.	for									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Robert Bennett, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany Cumberland Social Security Number 8. Date of Birth (Month, Day, Year) May 31, 1948 9. Birthplace (State or Foreign Country)

Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 1 X M 2 □ F Hours 214-52-1780 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17016 Eckhart Cemetery Road 21532 USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Laborer Boats Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Roy Bennett Elizabeth Eleanor Ritchey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Sue Bennett 17016 Eckhart Cemetery Road, Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date June 06, permit. Page 1 a Department of H 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) Frostburg Memorial Park Frostburg, Maryland 2010 21. Signature of Funeral Service Licensee . 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): physician sthe burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 N 2 🗌 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate; Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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			For State Registrar	State of Marylan		artment of H rtificate of L		d Mental H	ygiene Reg. No.	2010	18	621
	Physicia	an	1. Decedent's Name (First, Middle,	•	-			2. Date of D Month	eath Day	Year	3. Time of	Death
	/Medic		John Charles B			r		May	30	2010	4:14	A M
`,	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, or		eath		ounty of Death		
Fı	uneral		1322 Glendale D: 5. Social Security Number 6	<b>C</b> • 7. Age (In yrs. )	last birthday)	Hagerst	OWN If Under 24 F	rs. 8. Date of B	Was.	hington	Count	y or Foreign
	rector		141-05-2436	1 XM 2 □ F 94	Yrs.	Months Days	Hours M	lin. 8. Date of B (Month, L June 1.	ay, Year) 3 <b>, 1</b> 91	L5 Texa	place (State ontry)	J. 5. 5. 5. 7
pur	3		Usual Residence of Decedent  10a. State 10b. County	100 0%	y, Town or Lo	antica						
Maryla	f sho	lor	Maryland Washing								0d. Inside Ci 1 ☐ Yes	
the !	r 28a-	irect	10e. Street and Number	seem country mage	- CEOCOWI	10f. Zip Code			10g. Citize	en of What Cour		
th with	23a o	al D	1322 Glendale Da	r.		21742			U.S.			
r dea	erra	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.\	Was Decedent of Hi f Yes, specify Cuba	spanic Origin?	(Specify Yes or N		I. Race - Americ Black, White,		
s afte	, or it	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		I□Yes 2∏No	Specify:	ionto i noun, oto.,		Specity: Wh		
Z I Z I S-UU36 1 within 72 hours aft giene.	atural cel Es	Completed by	15. Decedent's	Education	16a, Deced	dent's Usual Occupa	ation			of Business/Inc		
hin 72	an "na Medi	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give life. L	kind of work done d OO NOT use retired;	luring most of v )	vorking	TOD: TING	0, 20011000,1110	adoli y	
ed with	t be	Con		College (1-4or 5+)	Vice I	President			Truc	k Mfg. (	Co.	
VIATION VIII DE FILE MENTAL HY	even	Be	17. Father's Name (First, Middle, La Peter Bogdanski	st)				Vame (First, Middle		· ·	1 .	
iaryiand ZIZIS-UU3B 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	mark	ည	19a. Informant's Name/Relationship	(Type Print)	10h Mailin	g Address (Street a		:banski B	_			_
Ma nd 2 sl alth an	27 is r trau		Claire Bogdansk		1	East Hambi					Coae)	
of Hea	r othe		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date		ation - City or To	wn, State	
Page ment	ant: li ury o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Litternovar nom otate	st Have	en Cemter	y 6-3	3-2010	Hage	rstown,	Marvl	and
paruffillore, Marylar permit. Pages 1 and 2 should be Department of Health and Ments	Import any inj once.		21. Signature of Funeral Service Lic	ensee	22	. Name and Addres	s of Facility	Oouglas A	. Fier	ry Funer	cal Ho	me
	= 60	1	Dungles	A being	1.3	331 Easter	rn Blvd	l. North	Hagers	stown, N		
			23a. Part 1. Enter the disease, or co shock, or heart ailure. List on Immediate Cause (Final	ly one cause on each line.	n. Do not ente	er the mode of dying	g, such as card	diac or respiratory	arrest,	- 1	Approximate Interval Bet Onset and I	ween
	ician dical		disease or condition resulting in death)	Pa. Colon	CA	week						-
Exar	niner			Due to (or as a consequ	ience or):							
To or	#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):							
ecute	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
e pe e	physician and the burial-transit	a E	rosaling in additify Education	Due to (or as a consequ	ience of):							
The law requires that the death certificate be executed	g phys	edical		d								
h cert	attending p	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23	d. Date of delive	erv	
deat	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		]Ectopic pregnancy ]Other (s <i>pecify)</i>						/ear
nat the	signed by the signed by the distribution of the detached in the signed signed in the signed signed in the signed s	Phy	9 Unknown									
ires #	be d	þ	Part II. Other significant conditions	contributing to death but not resu	ilting in the un	derlying cause give	n in Part I.			contribute to th	N 4	
nba.	speens	Completed							Yes 2	No 3☐ Prob	ably 400	Jnknown
he lav	e 2	dmo						- 24a. Was		24b. Were autor prior to cor death?	psy findings a npletion of ca	available ause of
an: ⊤			25. Was case referred to medical	1			26 Place of D	1 □Yes	2 No		2 □No	
- × ×	양분	10 B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	Other		eath <i>(Check only</i> Home 52 Res		☐Other (Specify	v)	
ng P	uneral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?		28d. Describe				
Attending r death.	the fu	cati	2 Accident investigati 3 Suicide 6 Could not	on be		M 1 □ Y	es 2□No					
after (	in by	ertification:	4 ☐ Homicide determine		me, farm, stre	et, factory, office		28f. Location ( City or To	Street and f wn, State)	Vumber or Rura	l Route Numi	ber,
To the Hospital or Attending Physikin 24 hours after death	/ filled	OL	29a. Certifier Certifying I	Physician: To the best of my know	vledge, death	occurred at the tim	e, date and pla	ace, and due to the	cause(s) a	nd manner as s	tated.	
he Ho n 24 h	pletel	ledical	(Check only 2 \ Medical Expone)	aminer: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my op	inion, death oc	ocurred at the time	date and pl	lace, and due to	the cause(s)	)
_ F	1 mg	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date s	signed (Month, I	Day, Year)	
SH	>		1 37			000	5599	74	0	/2/	10	
10	0		30. Name and address of person wh	completed cause of death (Item	23a) (Type, F	Print) [1110	medi	,	AMPU	5 RO	#13	0
	State	a /	31. Date filed (Month) Day Year)	32. Pegistrar's Signati	Agen ure	SNOWN	MO	2/7	40			
R	egistra	•	JUN 92	2010	6. A	to the						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8622 for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ GRAY BROWN ANNIE LAURA 2010 18:50 Mav Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Aug. 18, 1939 If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months North Carolina 1 M 2 X F 70 245-56-9910 Aug. Director Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10b. County 10a. State must be notified at Director Forestville Prince George's 1 K Yes 2 No Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA by Funeral 20747 6579 Hil Mar Dr., Apt. # 403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Examiner Armed Forces?
1 Yes 2 No 1 Never Married 2 Married **Black** ò within 72 hours after 1 Yes 2 No Specify: Maryland 21215-0036 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Dietitian n and Mental Hygier 7 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Davis Betty Gardner ၉ Dunn George I and 2 should be f Health and Menti item 27 is marked other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1210 Pickering Circle, Upper Marlboro, MD Rowland, Daughter Barbara Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Heritage Memorial Cem 06/05/2010 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E., Washington, DC 23a. Part 1. Enter the disease, or constitutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final phan monte Physician/ 150 recta disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day in the past 12 months? Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed a Yes 2 death? 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be ( Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural Accident 5 Pending 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063998

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 2 2010

Manesh Nachnani,

ddress of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Surratts

7503

Road, Clinton, MD

10-04369	
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onald Lee Ben		1- For State Registrar Certificate of		ygiene Reg. No.		0 18623				
Physicia ledical Exami	an/ iner	1. Decedent's Name (First, Middle,Last)  Ronald Lee Bennett, Jr.		2. Date of Death Month Day June 8, 2010	Year	3. Time of Death 2005 hrs				
		4a. Facility Name (if not institution, give street and number) 901 Dual Highway	4b. City, Town, or Location of Death Hagerstown	40	c. County of Death Washington	1				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  236-33-4280 1 M 2 F 31 Yr	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	,	1078 Co					
v any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Local		TUCL. 20,	19/0	10d. Inside City Limits				
with the Maryland ns 23a or 28a-f show be notified at once.	Director	West Virginia Wood Parkersb 10e. Street and Number	urg 10f. Zip Code	10g. Cit	tizen of What Cour	1 Yes 2 X No				
ith the N 23a or notified		1096 Red Hill Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	26104		S.A.					
death r iter	Fune	14. Race - Ameri White, etc. Specify: Whi	ican Indian, Black,							
15-0036 filed within 72 hours after of Hygiene. ed other than "natural", o t, the Medical Examiner o	leted by	3 Widowed 4 Divorced If Yes, Give Year 1 97 - 1 0 3 1  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	Yes 2 No specify:  Int's Usual Occupation (Give kind of working life, DO NOT use retire)	vork done 16b. I	Kind of Business/li					
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle, Last)	r Accountant	AC (First, Middle, Maiden	countin	ng Firm				
2121; wild be fil Mental I marked	Be	Ronald Lee Bennett, Sr.    Charlene Leeds								
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		Amy Bennett ?Wife 1096	Red Hill Road sition (Name of cemetery,	l.Parkers	burg, We Location - City or	estVirgini				
Baltimore, permit. Pages l ar Department of Hee Important: If ite injury or other tr		A Deposition 5 Other Secretary	'sComptony 6 1	4-10 Co	lliers,	WestVirgi				
m を表面面 Physician	$\dashv$	23a. Part I. Enter the disease, or somplications that caused the death. Do not enter to	Name and Address of Facility  Mar  009Harford Roa  the mode of dving, such as cardiac or	ZULLO Funda Baltimor respiratory arrest, sho	neral C <u>ore Mar</u>	hapel, P. A. vland2121  Paperoximate Interval				
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic card  Due to (or as a consequence of):			701, 01 1801.	Between Onset and Death				
	ner	Sequentially list conditions, if any, leading to immediate  b								
rted 1 ansit	Exam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
ob executed by sician and burial - transit	edical	AMENDED 23a27, per ME g90	5 7/1/ <u>10 TT</u>							
6876 certificat nding ph	51	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fe Pregnant at time of death 5 Ott	etal death 3 Ectopic pregnan		d. Date of delivery Month Da	ay Year				
that the death c	吾	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco i	use contribute to t	he cause of death?				
ords, P.O  w requires that the speen signed by should be detacted.	eted by			1 Yes 2	24b. Were aut	ably 4 Unknown opsy findings available				
of Vital Records, in Physician: The law requirement this certificate has been someral director, page 2 should	Completed			autopsy performed? 1 ✓ Yes 2 No	prior to co death?	ompletion of cause of				
Vital nysician: this certif	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check or 3 DOA Other Mursing		nce 6 🗸 Other:	Scene				
<b>- =</b> . ~ <b>=</b> .	<b>-</b>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	Injury 28c. Injury at Work? 2 1 Yes 2 No	28d. Describe how inju	iry occurred					
	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street (Specify)	ut, factory, office building, etc. 2	28f. Location (Street ar or Town, State)	nd Number or Rur	al Route Number, City				
	ल	29a. Certifier (Check only one)  2   Medical Examiner: On the basis of examination and/or investigate and manner stated.								
F = 5 - 0	M	29b. Signature and title of certifier  Asa Curles Curl	29c. License number O.C.M.E.		Date signed (Mont e 9, 2010	th, Day, Year)				
	7	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	)1						
Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signature	La al D							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

			Please	Type or Pri	nt in Bla	ack Ir	ndelible l	nk. Ensu	re All	Copies	Are Le	gible.			
	-	For State Registrar		State of M	aryland /		artment of tificate of		nd Me		ene g. No.	10	18624		
Physician Medica	_	1. Decedent's Name		Dona	ald C	الم	ns br	•	2	2. Date of Death Month	Z <sup>Day</sup>	Year V\V	3. Time of Death		
Examine		Anne	. Armdel	e street and number)  Medical (	enter			Anapal	17 1	10	4c. Count	mre	Armel		
Funeral Director		5. Social Security No. 577–52–9 Usual Residence of	211	Sex IXIM 2 □ F	e (In yrs. last b 71	irthday) Yrs.	If Under 1 Yea Months Day		Min.	B. Date of Birth (Month, Day, Y DEC • 02	<sup>(ear)</sup> 1938	g. Birti Cou Of C	hplace (State or Fpreign Intry) District Columbia		
a-f show ified at	Director	10a. State	10b. County  Anne Ar	undel	10c. City, To		eation Park						10d. Inside City Limits		
23a or 28 ist be not	erai Dir	10e. Street and Num 446 Retf	nber ord Driv	e			10f. Zip Code	1146		10	g. Citizen of USA	What Cou			
amin .	ed by Funeral	11. Marital Status  1  Never Marri 3  Widowed	ied 2 X Married	12. Was Decedent I Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates.	1056	5-  "	Vas Decedent of Yes, specify Cu	Hispanic Origin Iban, Mexican, F	n? (Specif Puerto Rid	y Yes or No- can, etc.)		ick, White זיי	3. Time of Death  Year  Of Death  Of Death  9. Birthplace (State or Foreign County) District  of Columbia  10d. Inside City Limits  1  Yes 2  No  What Country?  e - American Indian, sk, White, etc.  White  usiness Industry  sications  e)  State, Zip Code)  21146  City or Town, State  Ore, MD  K Funeral Home  K, MD 21146  Approximate Interval Between  3  Onset and Death  Monoset and Death  Monoset and Death  Monoset and Death  Were autopsy findings available orior to completion of cause of leath?  I yes 2  No  or (Specify)  and  or or Rural Route Number,		
than "natu	Completed	Elementary/Seco	15. Decedent's E cify only highest gr onday (0-12)			(Give k life. DC	O NOT use retire	e during most of	f working	-					
Aental Hygie rrked other tic event, th	ωŀ	12 17. Father's Name (F George	First, Middle, Last) Collins		i	Mai	nager	18. Mother's		First, Middle, Ma			lions		
m 27 is ma m 27 is ma ner trauma			Collins					et and Number o							
ment of H tant: If ite jury or oth		20a. Method of Disp 1 □ Burial 2 \$ 4 □ Donation		Removal from State	cemet	tery, crem	sition (Name of patory or other pa matory ,		ay 2°	7. I.		-			
Depart Import any inj once.		21. Signature of Fur	porar Service Licen	see		Ва 49	Name and Add rranco 5 Gov. 1	& Sons, Ritchie	P.A Hwy	. Severi	na Par na Par	k Fu	neral Home D 21146		
ysician/ Medical			t failure. List only o Final	plications that caused one cause on each line a.	. M	elar	r the mode of dy	ying, such as car	rdiac or n	espiratory arrest	,		Interval Between		
xaminer	<u>.</u>	Sequentially list cor if any, leading to im	nditions,	b. ———	a consequence										
al-transit	Examilia	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	lying	C	a consequence					_		12			
physiciar s the buria	ŧΙ			d											
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.  Medical Certificate: To Be Completed by Physician/Medical Exami	II ysiciali/ IV	F FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 9  Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal dea	ath 3 🗆 5 🗆	Ectopic pregna Other (specify)					ate of deli			
an signed build be deta	2	Part II. Other signifi	cant conditions	ontributing to death b	ut not resulting	g in the ur	nderlying cause	given in Part I.		23e. Did toba					
page 2 should t	adillo								- '	24a. Was an autopsy performe	3d9	prior to co death?	ompletion of cause of		
ertific sctor,	ו ע	25. Was case referre examiner?	,	Illana dal				Place of Death (	Check or						
this c	. 17	1 Yes 2,2			ent 2 ER/C		3 L DOA		ing Home	5 Residence	ce 6 🗆 Oth	ner (Specif	(y)		
after death.  Director: After in by the funera	III cate.	27. Manner of Death  1 Natural  2 Accident  3 Suicide	5 Pending Investigation 6 Could not be		, Year)	Time of injury	M 1	ork? Yes 2 No	- 1	d. Describe how	injury occur	red			
urs after of the plant of the p		4  Homicide	determined	building, etc	. (Specify)					City or Town, S	State)				
thin 24 hours the Funeral mpleted filled	MEGIL	29a. Certifier 1* (Check 2 only one) 3	Certifying Phy Medical Exam Certifying Nur	sician: To the best of iner: On the basis of ex se Practioner: To the	my knowledge kamination and best of my know	, death o /or investi wledge, d	ccured at the tin gation, in my opineath occurred at	ne, date and place nion, death occur the time, date an	ce, and c rred at the id place, a	lue to the cause e time, date and p and due to the ca	(s) and manr place, and du use(s) and m	ner as stat ue to the ca anner as s	ed. ause(s) and manner stated. stated.		
70 CC CC CC MI	1	sab. Signature and to	ide of centifier	N	~ MD	)	29c. Licen	00643	379	290	d. Date signe	d (Month,	Day, Year)		
1041	(	30. Name and addre	ss of person who	completed calcolof de	eath (Item 23a)	(Type, Pr	int) Jan	y Rhee	9	un Besty.	We Re	1541	2300 Annipils MD 21401		
State Registrar	3	11. Date filed (Month	MAY 27	2010 32. Registra	r's Signature	1. 4	back								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ Day KATHERINE Ρ. CONLEY 25 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST MONTGOMERY HOSP. ROCKVILLE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. MAY 22, MAINE 016-12-2316 90 Director 1920 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD. MONTGOMERY ROCKVILLE Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with TRAVILLE GARDEN CIRCLE 14411 20850 USA 72 hours after death Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ည HELEN HOOPER CARL PEINERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo BOYD CONLEY - SON 20850 . Page 1 and 2 sl ment of Health a tant: If item 27 is 9219 SCOTT DRIVE, ROCKVILLE, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State metropolitan crematory or other place) 5/27/10 ALEXANDRIA, VA. injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO., INC. N WASHINGTON, DC 20007 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CARDIAC RESPIRATORY ARREST Medical Due to (or as a consequence of) Examiner PLEURAL EFFUSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed NON ST. ELEVATION MYOCARDIAL INFARCTION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 2 9 Unknown ed by the a P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been signated by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopo, performed? autopsy death? certificate 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **X** No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 \sum Yes 2 \sum No injury 5 Pending Investigation Accident ☐ Accide ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0067512 MAY 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADAN, MD - SHADY GROVE HOSPITAL, ROCKVILLE, MD. BANGALORE 20850 32. Registrar's Signatur

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 1,8 per dr/fh,g204,06/16/2010dhb
Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elton Junior Conner 3. Time of Death Month Physician/ 2010 0610 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNION MEMORIAL HOSPITA 8. Date of Birth **04/10/3**L If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday Funeral Months Hours Min. Director PENNSYLVANIA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No T-ERNOAL 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral .5. 06 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 1952-53 Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NTER is marked other Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) and Mental ဨ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ONNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. CONNER 304 EURENIA AVE. FERNDALE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-3-10 EDENTEN, MID, Sign 22. Name and Address of Facility eral Septice License M0094Z 2601 MOUNTAN 20. MASAGEA 23a. Part 1. Enter the disease, or shock, or heart failure. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 30 years LOLON C Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Linknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed iis certificate has been si director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 \sum Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of eertifier 29d. Date signed (Month, Day, Year)

State Registrar

Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

Edward

31. Date filed (Month,

438946

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year May Medical Bernardo 2010 Corouz 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Days Hours Phillippines 101 105720/T909 Director 213-92-4740 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f Prince Georges Maryland College Park 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9014 Rhode Island Ave. #807 20740 Philippines 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 🗆 Xo Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐Xio Specify: 3 XWidowed 4 ☐ Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waiter Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည unknown Donata Corpuz Health and Ment tem 27 is marked ther traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lulu Alexander (Daughter) 6500 Edgerton Dr. Lanham, MD 20706 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any Injury or o ō cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2010 Lincoln Cemetery! Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 21. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. Interval Between mediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or illingry that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 2 No Yes 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many r of Death 28c. Injury at work? Certificate: Date of injury . Time of 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending Accident Suicide 1 Yes 2 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my kylowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D0058213 5/28/10 30. Name and address of person (who completed cause of death (Item 23a) (Type, Print) 20769 12150 Annapolis Rd #308 Glenn Dale, MD Farhad Jamali

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

JUN 0 2 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lawson Leo Duckworth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Western Maryland Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral 1 M 2 🗆 F Days Hours (Month, Day, Year) October 12, 1941 Country Maryland 213-40-4174 Director 68 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 No Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** USA 57 Jackson Street 21539 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Carpentry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawson Simeon Duckworth Beatrice Ada Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Duckworth - Wife 2434 Old Frostburg Road, Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date U7, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Frostburg, Maryland Loar Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 06 tructive Physician, hronic unr disease or condition Medical resulting in death) Due to (or as a conseque e of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No 1 Yes မြ Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No \_\_ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death account at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d Date signed (Month, Day, Year) 21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <sup>Day</sup> 2010 **Physician** Donald Wayne Davis  $\mathbf{P}^{\mathsf{M}}$ June 06, 8:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett 0akland 2192 Garrett Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/22/1959 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months Days Hours Min **Ж** м 2 □ F 218-74-8820 51 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It wound call Examiner must be notified at 0akland 1 ☐ Yes 2 No Director MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21550 2192 Garrett Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2♥No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify:White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Davis Maude Brown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Chestnut Grove Rd., Swanton, MD 21561 Jeremy Davis, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/08/2010 Mt. Zion Cemetery Mt. Zion, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home, 21. Signature of Funeral Service Licensee Katherene 21 N. Second St., Oakland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SECONDS Maule **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner overand if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician P.O. Box 68760, Physician/Medical the attending properties as use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐Yes 2 ☐ No as been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an The law las page 2 s autopsy performed? 1 □ Yes 2 ☑No certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{\text{\text{Nursing Home}}}\) 1 Nursing Home 5 \(\text{\text{\text{Residence}}}\) 6 \(\text{\text{Other}}\) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Mann Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kenneth Buczynski, MD 311 N. Fourth Street, Suite 1, Oakland, MD 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN - 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year 08:36 AM Medical 7010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) OH **Funeral** 1 🗆 M 2 🔀 F Days (Month, Day, Year) 10/25/1912 233-03-7260 97 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 1377 Becknel Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: Specify Completed 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Schulz Edgar Millhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1377 Becknel Ave. Odenton, MD 21113 Jacquelyn Debar Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill Cemetery | 5/27/2010 Piqua, Ohio Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Tall 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CONGESTIVE disease or condition resulting in death) HEART IDAY Medical Due to (or as a consequence of) Examiner MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte 4 ☐ Pregnant at time of death g ☐ Unknown 1 ☐ Yes 2 ≠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AOPTIC STENOSIS 1 Yes 2 No 3 Probably 4 Unknown has been sig te 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N page certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending after death.

Director: Aff
d in by the fur 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours after To the Funeral Dire completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tile of certific

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.

Please Type or Print in Black Indelible Ink, 1872010 AWS Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4:15 P <sup>M</sup> May 23, 2010 John G. Drake /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel La Casa Assisted Living Annapolis 8. Date of Birt 04/01/19239. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ▼ M 2 □ F 577-32-0656 Director 87 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Annapolis Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 88 East Lake Drive 21403 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ Specify: 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Law years Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Dracopoulos Fotinie Yana ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy G. Collins/ Sister 88 East Lake Drive, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏌 Cremation 3 ☐ Removal from State 4 □ Donation Kalas Crematory 5/26/10 5 ☐ Other (Specify) Edgewater, MD Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Uller 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a Ö 9 ☐ Unknown 9 Unknown Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1-1 3 Probably 4 Unknown 1 Tyes is certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfipt TAL DRIV 5 u 31. Date filed (Month, Day, Year) State MAY 26 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Age (In yrs. last birthday, If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Min. Mayth, 89, 12980 L&TISiana 434-41-7043 30 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7978 Nolpark Ct. Apt 303 21061 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1X Never Married 2 Married filed within 72 hours after of the same of Hygiene. ģ ☐ Yes Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced 4 Divorced Specify: Black Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry G & M(Specify only highest grade completed) Elementary/Second 12th College (1-4 or 5+) conday (0-12) Cook Restaurant Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) and Mental | is marked o Mental P pe 1 Chester K. Drew Sr Kathleen Sharps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or when Kathleen Sharps (Mother) 7978 Nolpark Ct. Apt 303 Glen Burnie, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metro Crematory 5-25-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wm me Pocse, Sim Sons Mortuary, 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee West St. Annapolis, Md. 21401 MO0 48 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory al shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 No g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ျ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? 5/20/3010 Z203 M 1 D Accident 2 2 No Investigation Pedestrian Struck 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 197 + STEWART CIVE determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier VIRGENER 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month)

DHMH 17 Rev 7/2009

State Registrar 32. Pagistrar's Signature

10-04297
Brennita Doleman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

rennita Dolem	an	1- For State	e of Maryland	•	irtment of <i>tificate</i> of		ı wenta		2010 eg. No.	6533
Physici		Registrar  1. Decedent's Name (First, Middle,La	st)					Date of Dea     Month		3. Time of Death
<sup>n</sup> edical Exam	ner	Brennita Denise 4a. Facility Name (If not institution, gi	Doleman		14	b. City, Town, or I	Location of D	June 6, 2	010 4c. County of Deat	0031 hrs
		Washington County Hosp			4	Hagerstown		eatti	Washington	
Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. Ia	ast birthday)	If Under 1 Year			rth(MM/DD/YYYY) 9. Bi	
Director		214-84-6567	2 XF	37	Yrs.	Months Days	Hours	Min. 01/25	/1973 Forei	ountry) MD
y		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Location	20				10d. Inside City Limits
d iow any			_			A1				1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	MD Washing 10e. Street and Number	gton	Hage	erstown	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
the M. a or 2.		210 Jonathan St				21740			USA	
s, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces?			Decedent of Hisp s, specify Cuban,		(Specify Yes or No lerto Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,
er deat , or its	Fun		1 Yes 2	X No		Yes 2X No			Specify: B	lack
urs aft tural" amine	d by	15. Decedent's Education (Specify of	or Dates:	pleted)	16a. Decedent	s Usual Occupation	on (Give kind	of work done	16b. Kind of Business/	
6 72 ho in "na cal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	during mo	st of working life.	DO NOT use	e retired)		
003( within jene. ner ths	dmc	12th			Custom	er Servi		ame (First, Middle,	Social Servi	ce Club
21215-0036 2uld be filed within 7 I Mental Hygiene. I marked other than	BeC	17. Father's Name (First, Middle, Las								
212 ould be I Ment mark	To E	Anthony Edward  19a. Informant's Name/Relationship (			19b. Mailing	Address (Street	and Number	ia Ann Go or Rural Route Nur	nber, City or Town, State	e, Zip Code)
MD id 2 sh lith and m 27 is		Virginia A. Dole	eman / Moth					erstown,	MD 21740	T 0.11
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", in jury or other traumatic event, the <u>Medical Examiner.</u>		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from Sta	ite c	rematory or other			Date	20c. Location - City or	
timent rtant:	1	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Rose	Hill Cen	retery	of Facility C	/11/2010	Hagerstown Minnich Fu	n, MD
Bal permi Depar Impo injur										
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused	the death.	Do not enter the	e mode of dying, s	such as cardi	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner	8 4	Immediate Cause (Final disease a	Cocaine To			Complic	ations	5		Death
		or condition resulting in death)	Due to (or as a conse	quence of	):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of	):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of	):					
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O, be exesician sician	Medical	-A	X AMENDED #6p	erFH#	23a.27-	28a-f.pe	erME.G	906.8/25/	2010 WS 23d. Date of deliver	
Box 68760, e death certificate by the attending physic ed for use as the but	N/W	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregn		al death 3	Ectopic pre			y Day Year
Sox 6876 leath certificate e attending phy for use as the l	hysician/N	past 12 months?  1 Yes 2 No 9 V Unknow	4 Pregnant at	time of dea	ath =	er (Specify)			Ť	1
D. B( t the de by the ached f	Phy	Part II. Other significant conditions	a OUNIOWII	but not re	sulting in the un	derlying cause gi	ven in Part I.	23e, Did to	bbacco use contribute to	the cause of death?
rds, P.O. requires that the been signed by hould be detact	þ		-		-			1 Yes	s 2 No 3 Pro	pably 4 🗸 Unknown
rds, requir	lete			-				24a. Was		utopsy findings available completion of cause of
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should I	ompleted						-		rmed? death?	
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner?						eck only one)		
f Vit Physic or this c	P	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatient 28b. Time of In		Other A Nork?	ursing Home 5	Residence 6 Othe	r:
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Division fal or Attendi rs after death. al Director: /	ficat	2 Accident Investigat 3 Suicide 6 X Could not	tion 5/5/2		10:52 a	, factory, office bu	uilding, etc.		Street and Number or Ru	
Divi spital or cours after neral Dir	Certification:	4 Homicide determine	nd 10 10 1	ellin	ıg			Hagerst	own, Maryla	nathan Street and 21740
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examine	cian: To the best of my	knowledg	e, death occurre	ed at the time, dat	e and place, death occurr	and due to the caus	se(s) and manner as stat and place, and due to the	ed. le cause(s)
To tl withi To tl	Medical	29b. Signature and title of certifier	and manner stated.	- Care in all		29c. License			29d. Date signed (Mo	
	-	111	1/	/	, ,	O.C.N	1.E. 0	CME	June 6, 2010	
		30. Name and address of person who	completed cause of de	ath (Item	23a)	1				
5H-1		Theodore M. King, Jr., Mi				111 Penn Stre	et, Baltin	nore, MD 21201	l	
Si	ate	31. Date filed (Month, Day Year)	32. Registrar	's Signatur	e A	1				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da May 26, 2010 **Physician** Year Louis Joseph DeFilippo 8:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1924 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Birthpiac Country) D.C. **Funeral** Months Days Hours Min. 579-20-3754 86 Director Usual Residence of Decedent 10a State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Prince George's Hyattsville filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6702 23rd Avenue 20782 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1943-45 Year or Dates: Specify: Completed by Specify: White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. House of Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer Representatives s 1 and 2 should be filed wi if Health and Mental Hygier Item 27 is marked other th other traumatic event, Im 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicola DeFilippo Antonia Pasante ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra Mary C. DeFilippo/Wife 6702 23rd Avenue, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 3 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final letastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mar Sequentially list conditions, Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No 1. Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours after death To the Funeral Director: filled in by To the

Baltimore, Maryland 21215-0036

State

(Check only

29b. Signature and title of certifier

20 31. Date filed (Month, Day, Year) 2010

cem

01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

10

7600

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

arroll Ave

29c. License number

68049

Takoma

29d. Date signed (Month, Day, Year)

Park

05-27-2010

State of Maryland / Department of Health and Mental Hygiene 2010 18635 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 25, 2010 **Medical Examiner** DREW DORSEY 0241 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Director Davs Hours 1X M 2 F 218-72-2724 Country) 47 09/17/1962 MD Usual Residence of Decedent any 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Montgomery Germantown Director 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13404 Stonebridge Terr. 20874 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried White etc 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2X No specify: Specify: Black ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Heavy Equipment Mechanic MD State Highway 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Maurice E. Dorsey Mary L. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Patsy L. Dorsey - wife 13404 Stonbridge Terr, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation Removal from State crematory or other place) All Souls Cemetery 6/2/10 Germantown, MD 4 Donation 5 Other Spe 22. Name and Address of Facility Snowden Funeral Home nature of Funeral Ser 246 N. Washington St, Rockville, MD 20850 23a. Part I. Enter the disease, ç complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cau e on each line 8etween Onset and /Medical Death Immediate Cause (Final disease a Acute coronary artery thrombosis Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine couse. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death Other (Specify) cate has been signed by the attr page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ξ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifications are the continuations of the continuation of director, 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 2 ဥ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Division 1 Yes 2 No 5 Pending the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 25, 2010 30. Name and address of person who completed cause of death (Item 28a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 11strar MAY 28 2010 32. Registrar's Signature Registrar

OCME

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Department of Books and Month Discussion	O C Department of realth and Wellia Hygiene.
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Vital Records, P.O. Box 68760,	sician: The law requires that the death certificate be executed	have a selection of the second second by the second

		,	For State Registrar	State of M	larylan	•	artment of H rtificate of L			giene Reg. No.	110	18636
	Dharisi		Decedent's Name (First, Middle	, Last)					2. Date of Dea		Year	3. Time of Death
	Physici /Medic		James Thoma	+ .*			r	M			010	7:27 p <sup>M</sup>
-"	Examin	er	4a. Facility Name (If not institution Ravenwood Luthe				4b. City, Town, or Hagersto				ounty of Death Washing	gton
	Funeral Director					a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Dec 23,	n Yea <i>r)</i> 1926	9. Birth	place (State or Foreign ntry) 7 Land
			Usual Residence of Decedent		10.00	~ .						Od. Inside City Limits
	larylar show	or	10a. State 10b. County Maryland Washin	aton	1 '	, Town or Lo cerstor						1 □Yes 2X No
	the M	Director	10e. Street and Number	igcon	nag	GELSCO	10f. Zip Code			10g. Citize	n of What Cou	ntry?
	3a or	al Di	19800 Tranquili	ty Boulevar	rd.		21742			U.	S.A.	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	- 14	. Race - Ameri Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any highly or other traumatic event, the Modical Experiment man by rediffed at once.	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	led 1 □Yes 2 X If Yes, Give Year or Dates:	No		1 □Yes 2 <b>X</b> No	Specify:		S		nite
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21	ithin 7 ne. nan "n	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired,	)		3.7		
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Maryland	d be fental   ked or	To Be	James Thomas I					Agnes V				
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationsh			19b. Maili	ng Addr <i>e</i> ss (Street &					o Code)
Σ,	and 2 ealth a n 27 is		David E. Draper	: / Son			St. Andre					340
ore	Jes 1 stoff He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	9		sition (Name of matory or other place	1	Date		ation - City or To	
Baltimore,	iit. Pa irtmer irtant: injury		4 Donation 5 Other (St		St.							g, Maryland
Ba	21. Signature of Fundar Service Licensee 22. Name and Address of Facility Bast-Stauf:							onsbo		21713		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause one ach line.									
			Immediate Cause (Final disease or condition resulting in death)  a.									Onset and Death
			Due to (or as a consequence of):									
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Φ	rtificat ng phy as the	<b>l</b> edic										
Вох	eath certific attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 ☐ Fetal	I death 3	☐ Ectopic pregnancy	/		23	d. Date of deliv	ery Day Year
Ö	the d by the	Physician/Me	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown		eath 5	Other (specify)					
S, P.	w requires that s been signed t should be deta	by PI	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.				the cause of death?
ord	requir	ted	Chraic only	nete Feli	~~~	Dire	<u></u>					bably 4 onknown
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of Vital	ysicia is cert directe	o Be	examiner?	Hospital: 1 ☐ Inpat	tient 2 🗌	ER/Outpatie	nt 3 DOA Othe		lome 5 ☐ Resid		□Other (Spec	ify)
o u	ding Physician: The I n. After this certificate hi funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury a <i>y</i> , <i>Year)</i>	28b. Time o Injury	Work		28d. Describe I	how injury o	occurred	
Division	death.	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation	niury - At ho	ome farm st		Yes 2□No	28f. Location (5	Street and	Number or Rui	al Route Number,
Div	al or A s after Il Direct	ertif	4 ☐ Homicide determ	building, e	etc. (Specif	y)	eet, factory, office		City or Tov	vn, State)	770111001 07 110	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical (	29a. Certifier 1 ☐ Certifyin (Check only one) 2 ☐ Medical	g Physician: To the bes Examiner: On the basis and manner s	of examina	wledge, deat tion and/or in	th occurred at the tire the transport of	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date	signed (Month	Day, Year)
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6,	H-3		30. Name and address of person	who completed cause of	Pinto.	1 23a) (Type,	nill SE	HACE	RSTOW	N	ms am	21740
	Sta Registr		31. Date filed (Month, Day, Year)	32. F gis	trar's Signa		hade					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1705 Baker St. N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days <sup>ar</sup>1946 1 🗆 M 2 💢 F Min. Aug 20 Maryland Director 214-54-8694 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d, Inside City Limits Director Maryland N/A Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Baker St. 21217 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Black 3 Widowed 4 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th 0 Day Care Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Coates Barbara Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Hideaway Loop Apt A Glen Burnie, Lolita Ennis(Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 KCremation 3 Removal from State Metro Crematory 5-27-10 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 2W Marme and and secret Famility Sons Mortuary, Lany B.R 821 West St. Annapolis, Md. 21401 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) Medical <sup>'</sup>Examinei Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director; After this certificate 2 🗌 No 1 Tyes 1 ☐ Yes 2 No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check R ... Curtifying Nurse Practicean To the best of my knowledge, death posint dist the time, date and place, and due to ti 29b. Signature and title of certifier SIGTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Cousins-Brown 828 Ν. Eutaw St. Baltimore, Md. 21201

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2

2010

MAN

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES JOHN DeMARR JUNE 9,2010 7:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 5145 CLAUDES PLACE WHITE PLAINS CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 578-24-7769 Hours 1 XM 2 □ F 87 WASH., D.C. Director Usual Residence of Decedent 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Bath: If it is a 275 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WHITE PLAINS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5145 CLAUDES PLACE 20695 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER HARRY CAMPBELL CO. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLAUDE LEROY DeMARR IRENE ELIZABETH DeMARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5145 CLAUDES PL. WHITE PLAINS, MD. 2 HENRIETTE DeMARR-SPOUSE WHITE PLAINS, MD. 20695 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 1 XBurial 2 Cremation 3 Removal from State TRINITY MEM. GARDENS 6-12-10 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ATHERO-SCLEROTIC HEART Onset and Death Immediate Cause (Final Physicia 1/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or): Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe CANCER COLON 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

completed filled in by

27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0026064

06-09-2010

V. ANMANGANDLA

10583-THEODORE GREEN BLVD WHITE PLAINS, MD-

State Registrar 31. Date filed (Month, Day, Year)

32. Regisar's Signature

Medical

10-04330 Donald R. Embrey

#### Please '

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	10630
State of Maryland / Department of Health and Mental Hygiene	10000
G 1151 1 5 5 11	

		1- For State Certificate of Death Registrar	Reg	g. No.				
Physici Medical Exam	5 Sunc 1, 2010							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7409 Lanham Lane  4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's				
Funeral Director		5. Social Security Number 217-74-1978 6. Sex 1 T. Age (In yrs. last birthday) 54 Yrs. 6. Sex 1 T. Age (In yrs. last birthday) 2 T. Age (In yrs. last birthday) 3 T. Age (In yrs. last birthday) 4. B. Date of Birth(MM/DD/YYYY) 9. Birthgarthay 5. Social Security Number 2 T. Age (In yrs. last birthday) 4. B. Date of Birth(MM/DD/YYYYY) 9. Birthgarthay 5. Social Security Number 2 T. Age (In yrs. last birthday) 4. B. Date of Birth(MM/DD/YYYYY) 9. Birthgarthay 5. Social Security Number 2 T. Age (In yrs. last birthday) 4. B. Date of Birth(MM/DD/YYYYY) 9. Birthgarthay 5. B. Date of Birth(MM/DD/YYYY) 9. Birthgarthay 5. B. Date of Birth(						
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits			
	or	Maryland Prince George's Adelphi			1 X Yes 2 No			
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number         10f. Zip Code           10414 Tullymore Street         20783	109	g. Citizen of What Co USA	untry?			
r death wi or items must be	Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes, specify Cuban, Mexican, Puerto Forces? 1 Yes, Give Year  1 Yes, Give Year  1 Yes, Give Year		14. Race - Ame White, etc. Specify: Whi	rican Indian, Black, _te			
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retire		16b. Kind of Business				
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Completed	Elementary/Secondary (0-12)  12  College (1-4 or 5+)  Truck Driver	ed)	Defense (	Contractor			
21215-0036 vald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Herbert C. Embrey  18. Mother's Name (Ruth N.	LeBeau		-			
imore, MD 21 Pages I and 2 should ment of Health and Me tant: If item 27 is ma or other traumatic es	7	19a. Informant's Name/Relationship (Type, Print)  Ruth N. Embrey / Mother  19b. Mailing Address (Street and Number or Ruth 10414 Tullymore Street)	, Adelp	hi, MD 20	783			
Ore, ges l an t of Hea : If iter		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City o				
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Metropolitan Crematory 6/9 21. Signature of Funeral Service Licensee 22. Name and Address of Facility			a, Virginia imore Avenue			
Dep De Inje		Gasch's Funeral Hom	e, P.A.	Hyattsvill	Le, MD 20781			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	-		Approximate Interval Between Onset and Death			
Examiner	j	Immediate Cause (Final disease or condition resulting in death)  a Cardiac arrhythmia associated with carring the consequence of:	агатоше	зату	2500.			
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):						
760, icate be executed physician and the burial - transit	1	d						
760, icate be er physiciar the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	\			
687 certifica ding pl		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnan	су	Month	Day Year			
Box 687 e death certific the attending	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)						
F. P.O.	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
ords, F w requires s been sign should be	ed	Cocaine use	24a. Was ar		utopsy findings available			
COF ne law r te has b ge 2 sh	Completed	· · · · · · · · · · · · · · · · · · ·	autopsy perform 1 ✓ Yes 2	ned? death?				
Vital Reco ysician: The law his certificate has director, page 2 s	a)	25. Was case referred to medical 26.Place of Death (Check or		1.0	2 10			
f Vita Physici rrthis c		Tes 2 No		esidence 6 🗸 Othe	er: Scene			
on of anding Phath.	Ë	Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	28a. Describe no	w injury occurred				
Division of Vital Records, ital or Attending Physician: The law requir us after death.  ral Director: After this certificate has been siled in by the funeral director, page 2 should the founding that the funeral director, page 2 should the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City			
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of cone)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.						
of P. S. S.	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed <i>(Mo</i>	onth, Day, Year)			
0 1	}	30. Name and address of person who completed cause of death (Item 23a)						
	ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature						
Regist	300	JUN 1 0 2010 Jenne B. Jack						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day 4 Physician/ Year 2010 Paul Donald Exline 505a M un Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. 1 🗓 M 2 🗆 F Days June 14, 1927 Director 218-24-1457 82 Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13322 Exline Road 21750 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United Telephone Co. 8 <u>Lineman</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William E. Exline Estella P. Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Donald L. Exline/Son 13320 Exline Road Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt.Olivet Presbyterian 06/09/2010 Hancock, MD 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Lice -M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUHG COLLAPSE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MINIRATION DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine MASSIVE monlo or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide City or Town, State) the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

30. Name and address of person who GHA LAVA

31. Date filed (Month, Day, Year)

(COM)

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1190

		For State	State	of Marylan	-	artment of F tificate of D		l Mental Hy	20	10 18641	
		Registrar  1. Decedent's Name (First, Middle	, Last)		Cei	uncate or L		2. Date of De	Reg. No.	3. Time of Death	
Physicia Medi		Vincent F. Favara							Year 2145 M		
Exami		4a. Facility Name (if not institution	4b. City, Town, or Location of Death			4c. County of Death					
		Western Maryland Regional Med. Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				Cumbe	erland	rs. 8. Date of Bi	Allegany  Birth 9. Birthplace (State or Ford		
Funeral Director		074-36-8462	1 <b>X</b> M 2 □ F	64	Yrs.	Months Days	Hours Min		3,1945	Brooklyn, NY	
d t t	١. ا	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loc	ation				10d. Inside City Limits	
arylan a-f sh ified a	Funeral Director	WV Mine	ra1	100, 010		yser				1 🗆 Yes 2 🗶 No	
the M or 28 e noti	Ę	10e. Street and Number			11.0	10f. Zip Code			10g. Citizen of	What Country?	
s 23a nust b	nera	Rt. 6, Box 6	446 Kno	bley Ro	ad	267	726		τ	JSA	
death ritem iner m	/ Fur	11. Marital Status	Armed Fe	edent Ever in U.S orces?	3. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? ( n, Mexican, Pue	Specify Yes or No erto Rican, etc.)		ce - American Indian, ck, White, etc.	
s after al", o	d by	1 ☐ Never Married 2 🗶 Mar 3 ☐ Widowed 4 ☐ Divorced	If V O!	2 □ No ve vates. <b>Viet</b> i	nam 📗	☐ Yes 2 🛮 No	Specify:		Specify.	White	
2-0-0-1	plete		nt's Education		16a. Deced	ent's Usual Occup		orkina	16b. Kind of B	susiness Industry	
Z I Z I 3-UU30 within 72 hours after jiene. er than "natural", o the Medical Exam	Completed	Elementary/Seconday (0-12)	T	1-4 or 5+)	life. DO	D NOT use retired) <b>Electric</b> a	_	_	Par	per Mill	
Hygie Other ent, ti	Be (	17. Father's Name (First, Middle, I	_ast)		<u> </u>	LICCTIC		ame (First, Middle	· · · · · ·		
Vidina Id be filed Mental Hy arked ott	မ	Andrew Favara	L				Cathe	rine Mir	abile		
NICT) 2 should th and N 27 is me trauma		19a. Informant's Name/Relations			1	g Address (Street a			er, City or Town, S	State, Zip Code)	
and 2 Health em 27 ther tu		Annette Favara 20a. Method of Disposition	/Wife	20h E		6, Box 64	446 Key		26726	- City or Town, State	
Dallillore, IMarylating Z.IZ.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		n State	emetery, crem	natory or other place	1	June 12 2010		rland, MD	
Dallii permit. P Departme Importar any injur		21. Signature of Funeral Service		1116		. Name and Addres		Smith Fu			
		Dulan	Bours		4	85 S. Mai	in Stree		er, WV	26726	
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	only one cause on e	ach line.		-	_			Approximate interval Between	
Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)		CURREN		1ALL LY	MPHOCY	TIC LYI	YPHOM +	Onset and Death	
Examiner		rooding in doding	Due to	(or as a consequ	uence of):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):						
cuted nd transit	xam	Cause (Disease or linjury that initiated events	c	,							
oe exe	dical Examiner	resulting in death) Last	Due to	(or as a consequ	uence or):						
requires that the death certificate be executed requires that the death certificate be executed been signed by the aftending physician and should be detached for use as the burial-transit	1 (1)		d								
certifica ending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	ev		23d. Da	ate of delivery	
death death after	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre	gnant at time of	death 5	Other (specify)	-,		Mo	onth Day Year	
at the	/ Ph	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	obacco use cont	tribute to the cause of death?	
J, L	q pe							_ 1 🗆	Yes 2 □ No	3 ✓ Probably 4 ☐ Unknown	
iw requ	plet							24a. Was		Were autopsy findings available prior to completion of cause of	
The la tate has bage	Com							perf	ormed?	death? 1 ☐ Yes 2 Ø No	
VICAL DECOLUS, ysician: The law require: s certificate has been sit director, page 2 should t	Be	25. Was case referred to medical examiner?	Hospital:	<u> </u>		LOthe	ace of Death (C	neck only one)		12	
Phys Prthis eral dii	e: To	1  Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2  of injury	28b. Time of	28c. Injury	4 ∟ Nursing y at	Home 5 Res 28d. Describe	dence 6 🗌 Oth		
ath. rr. Afte	ficat	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi	gation	nth, Day, Year)	injury	M 1 🗆	? Yes 2 🗆 No				
al or Attending Pl s after death. Il Director: After the	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place	e of Injury - At ho ling, etc. (Specify		eet, factory, office		28f. Location ( City or To		er or Rural Route Number,	
DIVISION OF VICE INSCRIPTION OF THE PROPERTY IN TO THE HOSPITAL OF THE PROPERTY OF THE HOSPITAL OF ARTHORING Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	Physician: To the	best of my know	ledge death o	occured at the time	, date and place	and due to the o	ause(s) and mann	ner as stated.	
n 24 h	Medical	(Check 2 Medical E	xaminer: On the ba	isis of examination	n and/or invest	igation, in my opinio	on, death occurre	d at the time, date	and place, and du	e to the cause(s) and manner stated.	
To the voith is coming		29b. Signature and title of certifier	11	11/		29c. License	e number	,		d (Month, Day, Year)	
				//		Da	23/		JUNE	9,2010	
_		30. Name and address of person  Qamar Zaman		se of death (Item 904 Set			erland,	MD 2150	12		
Sta	te	31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ture		or rand ,	- LIJC	_		
Registr		JUN 1	5 2010	Deneva	B. 1	back					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eleanor Lorraine Footen June 6:15 P M 2010<sup>ea</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Allegany Moran Manor Health Care Center Westernport Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)
Maryland 216-22-1166 1 M 2XXX Days Hours (Month, Day, Year Sept. 4 92 Director 1917 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Allegany Westernport MD 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 431 21562 Vine St. United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) School System Elementary/Seconday (0-12) 12 College (1-4 or 5+) Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dunk Bessie Batie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise Hanna/ sister 417 Walnut St, Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 06/08/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Teken 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final My o control Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underpring Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 1 Urknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natura. 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and a state of the cause of the Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate of Marylar	•	irtment of F tificate of E			giene Reg. No. $\nearrow$	A street	18643
	Physicia Medic		Decedent's Name (First, Middle, Last)     MAY	[.	GREE	NWOOD		2. Date of Dea Mont!5	2 <sup>D</sup> 28 26,	Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street a	nd number)	Vater	4b. City, Town, or	Location of Death		4c. County	of Death	`
	Funeral Director		5. Social Security Number 6. Sex 1 ∠ M 2	7. Age (In yrs. 73		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 23	h	9. Birtho	olace (State or Foreign try) JERSEY
	and show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f otified	Funeral Director	DELAWARE SUSSEX		FRANKF	ORD					1 ☐ Yes 2 💢 No
	th the 3a or t be n	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of W		try?
	eath w	nue.	37129 ALABAMA DRIVE  11. Marital Status 12. Wa	s Decedent Ever in U.	S. 13. W	1994 /as Decedent of His	FD spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-		JSA - America	an Indian,
2000	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 X Married 1 If Y	ned Forces? ☐ Yes 2 █️XNo es, Give ar or Dates.		Yes, specify Cubar  ☐ Yes 2 X No		Rican, etc.)		k, White, e	etc.
5	"natu	Completed	15. Decedent's Education (Specify only highest grade com		(Give k	ent's Usual Occupa ind of work done d	ation uring most of worki	ing	16b. Kind of Bu	siness Inc	dustry
7	vithin 7 jiene. er than the M		Elementary/Seconday (0-12) Co. 12	lege (1-4 or 5+)		NOT use retired) MEMAKER			OWN HO	ME	
2	e filed ved other event,	To Be	17. Father's Name (First, Middle, Last)		•		18. Mother's Name				
l y la	should be file h and Mental H 7 is marked o rraumatic eve	-	CHARLES AMEY  19a, Informant's Name/Relationship (Type, Prin.		10h Mailin	a Address (Street a	MALLET'		READ		Pardal .
M	and 2 sho Health an tem 27 is ther trau	- 3	WILLIAM K. GREENWOOD	•	T	•					
ב ב			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Remov	al from State	cemetery, crem	sition (Name of atory or other place	e)	Date	20c. Location -		
Dalling	교원보충		4 Donation 5 Other (Specify)  21. Signat & Fangral Service Licensee	CRE		OF DELMA		/10	DELMAR,	DEL.	AWARE
ם	permi Depar Impo any ir	1.0	I Clarky IN H	all			UNERAL H	OME, SEI	LBYVILLE	DE, DE	. 19975
			23a. Part T. Enter the disease, or complication shock, or heart failure. List only one cause		h. Do not ente	0 1	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
~	Ph∵sician/ Medical	8 8	Immediate Cause (Final disease or condition resulting in death)	ue to (or as a conseq	AGE	KENAL	1/15	EAST		- 3	Onset and Death
	Examiner			de to (or as a conseq	dende oi).						
	sit sd	Sequentially list conditions, if any, leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Co. Due to (or as a consequence of):  Due to (or as a consequence of):									
	execute in and ial-tran	Еха	that initiated events C. —	Due to (or as a conseq	uence of):						. <u></u>
3	icate be executed physician and s the burial-transit	edical	d								
2	ath certifica attending pl		IF FEMALE: 23c. If y	es, outcome of pregna	ancy				22d Dat	e of delive	an/
Š	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	Live Birth 2 Fets Pregnant at time of Unknown	aldeath 3 🗌	Ectopic pregnance Other (specify)	y 		Mor		Day Year
5	at the o		9 Unknown 9 L  Part II. Other significant conditions contributi		sulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	ibute to th	e cause of deaths?
<u>0</u>	uires th signe Ild be c	ed by									pably 4 D Unknown
2	aw requas beel 2 shou	Completed						24a. Was a		Vere autop	osy findings available mpletion of cause of
ב ב	r: The la icate h r, page		Of Wassesser	<u>.</u>				perfor 1 Yes	rmed?	leath?	2 No
אונס אונס	ysiciar s certifi directo	To Be	25. Was case referred to dical examiner?  1  Yes 2 No Hospita	: 1 Inpatient 2 I	ER/Outpatient	Othe	r: 4 Nursing Ho		ence 6 🗆 Othe	r (Specify)	
5	ing Ph fiter thi uneral		27. Mann of Death  1 Natural 5 Pending	. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at ?		ow injury occurre		
200	Attendi death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injury - At ho	ome, farm, stre		Yes 2 No	28f. Location (S	treet and Numbe	r or Rural	Route Number,
5	tal or / rs after al Dire ed in b		4 ☐ Homicide determined	building, etc. (Specify	/)			City or Town			
	Hospi 24 hou Funer eted fill	Medical	29a. Certifier 1 Certifying Physician: T	the basis of examinatio	n and/or investi	gation, in my opinio	n, death occurred at	the time, date ar	nd place, and due	to the cau	use(s) and manner stated.
	To the within To the comply	Σ	only one) 3 L Certifying Nurse Pract 29b. Signature and title of certifier	ioner: To the best of m	y knowleage, a	29c. License			29d. Date signed		
	10		Malante	1/	MD	D6	0515		5/29	110	
	M		30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Pr	rint)	SHUKE	DR.	SALICH	OKY	MD 2/804
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	turg.	ald	-110	+//	141211		

DHMH 17 Rev 7/2009

10-04046 Sylvia Gould

## Plea

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	State of Maryland / Department of Health and Mental Hygiene	2 U I	U	1	0	6	hip

		1- For State Certificate of Death Reg. No.							
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  Sylvia GOULD  2. Date of Death Month Day May 27, 2010  Year	3. Time of Death 0620 hrs						
		4a. Facility Name (if not institution, give street and number)  AAA atrium classic assisted living  4b. City, Town, or Location of Death  Silver Spring  Montgomery							
Funeral Director		5. Social Security Number 212-18-8126 6. Sex 1 Months Days Hours Min. Feb. 4, 1921 Foreign Counts Feb. 4, 1921 Feb. 4, 1921 Foreign Counts Feb. 4, 1921 Fe							
ow any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	10d. Inside City Limits  1 Yes 2 X No						
e Maryland or 28a-f sh	Director	MarylandMontgomeryPotomac10e. Street and Number10f. Zip Code10g. Citizen of What Co10248Democracy Lane20854United States	untry?						
2 hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Armed Forces? White, etc.	erican Indian, Black,						
ours after d atural", or taminer m	by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business	nite S/Industry						
	Completed	12 Administrative Assistant Health. E	rtmént of Education &						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Oopartment of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	B	17. Father's Name (First, Middle, Last)  Herman Gould  18. Mother's Name (First, Middle, Maiden Surhame)  Fannie Prissman  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta							
MD 2 nd 2 shoul alth and M om 27 is m	<u>م</u>	19a. Informant's Name/Relationship (Type, Print) Lawrence Gould, Nephew  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 10248 Democracy Lane, Potomac, MD 208  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Disposition)							
imore, Pages 1 a ment of He tant: If ite		1 M Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Judean Memorial Gardens 05/28/10 01ney, N	1D						
0	4	21 Signature of Funerius Service Licensee M01008 22. Name and Address of Facility Torchinsky liebrew Fur 254 Carroll St., NW, Washington, DC	20012						
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Approximate Interval Between Onset and Death						
	Į.	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):							
d sit	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Under the Company of the Compan							
execu ian and	Medical E	d. UNPENDED AMENDED							
Box 68760, e death certificate be the attending physicied for use as the buried for the buried for use as the	Physician/Me	IF FEMALE:     23c. If yes, outcome of pregnancy     23d. Date of delive       23b. Was decedent pregnant in the past 12 months?     1	ry Day Year						
ires that the de signed by the be detached f	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro							
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for uses as	Completed	24a. Was an autopsy performed? death?	utopsy findings available completion of cause of						
al Re	Be Co	25. Was case referred to medical 26. Place of Death (Check only one)	es 2 No						
of Vit Physic er this c	유	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other4	er: Scene						
ivision of or Attending Phatter death.  Director: After the by the funeral	ertification:	1 V Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	12 4 14 67						
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	OF	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Ror Town, State)							
Di To the Hospital within 24 hours To the Funeral I	edica	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	he cause(s)						
5	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mc  May 27, 2010	ontn, Day, Year)						
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta Regist	_	31. Date filed (Month, Day, Year) 2010 32 Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28 2010 ALLEN GIBSON 11:58 P M Α. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 604 Cappy Avenue Capitol Heights Prince Georges 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Davs Hours Min March 10,1916 94 Trinity, NC Director 240-03-3267 Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c, City, Town or Location the Maryland 10d. Inside City Limits Director Prince Georges 1 X Yes 2 ☐ No Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 604 Cappy Avenue 20743 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 24 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify. If Yes Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Veneer Salesman Private and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental Joseph Α. Gibson Roella Penry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph G. Gibson/ Son 604 Cappy Ave., Capitol Heights, MD rartment of Health rortant: If item 27 injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 5,2010 Trinity Cemetery Trinity, NC 4 ☐ Donation 5 ☐ Other (Specify) per lit.
Det artm
Importa
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? detached for Month Day Vear 2 No 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' 1 🗌 Yes Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Natural 5  $\square$  Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completed filled in by the fur 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Ivan Zama 9200 Basil Court Suite #200, Largo, MD 20774 31. Date filed (Month, Day You JUN 0 2 2010 32. Registar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

29b. Signature

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Month 51,550 5:30 P 112 a beth 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth's Nursing Home None Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 XF Days 219-01-1737 Director 95 Yrs. 1/20/1915 MDUsual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23s or 28s-1 show any injury or other traumatic event, Ite Madical Examiliant France Confidence. 1 ☐ Yes 2F No Completed by Funeral Director Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9612 Larchmede Court 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J. Edward Chaney Sr. Emma Irene Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Grisso - Daughter 21042 9612 Larchmede Ct. Ellicott City Mp 21042
Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/4/10 Prospect Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mt. Airy, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 M01044 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death fmmediate Cause (Final **Physician** disease or condition resulting in death) dementio /Medical Due to (or as a consequence of) Examiner FTT Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physicien and the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death P.O. 1 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 ☐ Probably 4 YUnknown pieted 1 ☐ Yes 2 ☐ No cate has been a 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Com certificate OA 1 ☐ Yes 2 ☐ No 1 Yes 2 WNo director 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No the 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRIO R111615 5131110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 Benson Avenue Goldsborough Baltmore 7 notes MD 31. Date filed (Month, 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month CASSIE ROSETTA HOPKINS SOGM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Center Cheverly Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Director 216-22-0977 80 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f showther traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Hyattsville 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1104 Consideration Lane 20785 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Domestic worker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Charles Hopkins Minnie Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Hawkins - daughter 1104 Consideration Lane, Hyattsville, MD 20785 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State tery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) Memorial Cemtery: 6/1/10 Sandy Spring, MD f Funeral Service Lic Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EZIES Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury YHESEMA signed by the attending physician and de detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last STABETES Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Live 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown been 8 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 r autopsy performed?

1 Yes 2 No death? 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? To the Hospital or number of within 24 hours after death.
To the Funeral Director: After this committeed filled in by the funeral directors of the funeral directors. 1 Yes 2 X No Other: 유 1 A Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) muxemine Abdella, m.D. D0059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785

State

Registrar

Makemil

31. Date filed (Month, Day, Year)
MAY 28 2010

back

W.D.

6005 Landover Rd, #3, Cheverly, MD

Aborella

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2010 May 20 5:15 PM Johnnie Hatten /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehab Ctr. Berlin Worcester Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 XM 2 ☐ F Months Hours 76 Director 231-42-8449 8-15-1933 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at Director 1 ☐ Yes 2 No Newark MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21841 USA by Funeral 8276 Patey Wood Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Hatten, Johnnie Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) George Burke Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Iffall Once. <u>Truck Driver</u> Cropper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Hazel Mae Lockwood Horace Ginn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8276 Patey Wood Road, Newark, MD 21841 <u>Joyce Anne Hatten/Wife</u> 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Williams AME Cem 6-1-2010 Newark, MD
22. Name and Address of Facility 917 W. Isabella St.
Roppie Smith 21. Signature of Funeral Service Licenses Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** gncer -unc 6mo /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Cerebral 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A death. 1 Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) H 0070020 ale 05, 21, 2010 30. Name and address of person who completed cause of death (Itym 23a) (Type, Print) Diane Ceruzzi, 9715 Healthway, Dr, Berlin, MD DO 21811

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month.

JUN 0 1 2010

32. R gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 Higgins 11:55 A M Darwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 13623 Rockcliff Dr. Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ■ M 2 □ F Hours (Month, Day, Year) eb. 19 **Director** 214-28-0828 78 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 13623 Rockcliff Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ■ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) International Sales Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ John Martin Higgins Elizabeth Teresa Holtzner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Higgins / Wife 13623 Rockcliff Dr., Hagerstown, MD 21742 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Kermation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 6/3/2010 Smithsburg, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mus 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examil To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 166930 AM Declive 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 5H-04

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State

31. Date filed (Month, Day, Year)

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			For State Registrar	-	epartment of Health and N Certificate of Death		ne N2010 186	50
	Physici	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of D	
	/Medi	cal	Blanche Louis		4b. City, Town, or Location of Death	June 2,	2010 Year 9:39 4c. County of Death	
	Examir	ner	4a. Facility Name (If not institution, give street 201 Weldon Court	ana number)	Boonsboro		Washington	
	Funeral Director		5. Social Security Number $215-18-1105$ 6. Sex	2XF 88		8. Date of Birth (Month, Day, Ye March 14	9 Birthplace (State or	Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City	/ Limits
	Marylan -f show	to	Maryland Washington		ville		1 □Yes	
	h the	Director	10e. Street and Number	IGIOA	10f. Zip Code	10g.	Citizen of What Country?	
	ath wit	ral	3006 Kaetzel Road		21758		U.S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ih. Michal Eventina must be notified at once.	by Funeral	1 Never Married 2 Married	Vas Decedent Ever in U.S. vrmed Forces? Yes 2 M No 'Yes, Give 'ear or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
Baltimore, Maryland 21215-0036	hin 72 ho e. an "natur Mudical	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	n 16a.  npleted)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing 16t	b. Kind of Business/Industry	
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and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)	1	18. Mother's Nam	e (First, Middle, Mai Cona:		
ary	should nd Me mark ımatic	은	Turner C. Hol		Mailing Address (Street and Number or Ru.			
, Ma	and 2 salth ar		David T. Thompson /		006 Kaetzel Road Kr			
ore	Pages 1 and the sut: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Date 200	c. Location - City or Town, State	
tim	permit. Page Department ( Important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify)				rederick, Maryla	
Bal	permi Depar Impo any ir		21. Signature of Funeral Service Licensee	(holas	22. Name and Address of Facility Bas 7606 Old National			
	Physician		23a. Part 1. Erper the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition			or respiratory arrest,		een
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of	f):			
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (of as a consequence of	1).			
o,	rificate be executed og physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence o	f):			
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O. Box 6	ath cer attendir for use	Physician/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2□ Fetal death □Pregnant at time of death □Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Ye	ear
σ.	that the denetached		Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of de	eath?
rds	quires tha en signed uld be det	ed by				1 ☐ Yes	2 No 3 Probably 4 U	nknown
of Vital Records,	The law requii te has been s age 2 should	Completed				24a. Was an autopsy performed	24b. Were autopsy findings a prior to completion of ca death?	vailable use of
'ita	hystcian: The la his certificate has I director, page 2	Be C	25. Was case referred to medical examiner?		26. Place of Dear	1 □Yes 2 th (Check only one)	No 1 ☐ Yes 2 ☐ No	
of V	Physic rthis corral dire		1 Yes 2 No Hospi	1 Inpatient 2 ER/Out			e 6 Other (Specify)	
Division	tending I eath. tor: After the funer	Certification: To	1 Pending 2 Accident investigation		jury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Divi	ital or At Irs after d ral Direct led in by	Certifi	4 Homicide determined	Be. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Numb itate)	er,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
	Vith Vith Common	Σ	29b. Signature and title of certifier	) Man	29c. License number		Date signed (Month, Day, Year)	
			30. Name and address of person who comple	tod gauss of death (Item 22a) (	194656)		JUNE 03, 201	0
31	4-16			1012 2031		BOONSBOR	w MD 2171	3.

DHMH 17 Rev 1/2001

State Registrar

sistrar's Signature

GHA ZAYA UM 31. Date filed (Month, Day, Year) JUN 9 3 2010

			Please Type or Print in Black AMEND ITEM#23a, print State of Maryland / D  State of Maryland / D  State Amend Item 5 per fh, g904,067	Indelible Ir	nk. Ensure ApperCNP, G90	All Copies / 05 7/13/2 //ental Hygie	<b>Are Legible</b> 010,WS ene	· <b>.</b>
			State Amend Item 5 per fh, g904,067	<b>25/2010dhb</b> Certificate of	Death	Reg	g. No. 2 1 1	1 18651
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)		-	2. Date of Death		3. Time of Death
	Medic	al	Charles R. Jones, Jr.		and a self-or of Doroth	May 22,	1	3:30pm м
	Examin	er	4a. Facility Name (if not institution, give street and number)  Spring House of Silver Spring	Silve	or Location of Death  Spring		4c. County of Dea Montgome:	ry
H	Funeral Director		5. Social Security Number 2.32 - 16 - 66.37 1	Months Days		8. Date of Birth NOV • 21	9. Bic	rthplace (State or Foreign punity) ninond, VA
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
	farylar Ba-f sl tified	Director	MD Montgomery Silver	Spring				1 XYes 2 No
	the Na or 2		10e. Street and Number	10f. Zip Code			g. Citizen of What C	
	th with ms 23 must	Funeral	2201 Colston Drive #309A	20910	Historia Odaisa (6-		United St	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🏋 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	13. Was Decedent of If Yes, specify Cui  1 ☐ Yes 2 1 N	ban, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh Specify: B	te, etc.
2-0	2 hour "natur	plete	15. Decedent's Education 16a. [ (Specify only highest grade completed) ((	ecedent's Usual Occi	upation e during most of work	ing 1	6b. Kind of Busines	s Industry
2121	vithin 7; giene. er than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	fe. DO NOT use retire Painter	d)	τ	J.S. Gove	rnment
and	be filed vental Hyg ked oth	To Be	17. Father's Name (First, Middle, Last) Charles R. Jones, Sr.		18. Mother's Nam Hattie	e (First, Middle, Ma Morris	iden Surname)	
lary	should and Me is mar aumati		19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Stree	et and Number or Rur	al Route Number, C	City or Town, State, 2	(ip Code)
٥,	and 2 sealth lealth sm 27			Marietta Disposition (Name of	Place, N.		ngton, DC  Oc. Location - City of	
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or ot		1 V Rusial 2 Committee 2 Removal from State Cemetery	n Memoria	L 05/2	9/2010	Suitland,	MD
Ball	permit Depart Impor any in		21. Signature of Funeral Service Lipensee					vice, Inc. n, DC 20012
	nysician	2 2	23a Part 1. Enter the disease, or complications that caused the death Do no shock, or heart failure. List only one cause on each line.	enter the mode of dy	ring, such as cardiac			Approximate Interval Between Onset and Death 10 years
	Medical Examiner		disease or condition resulting in death)  a. Metastatic Pro Due to (or as a consequence of Advanced Demen		.61			6 10 years
Z.	sit .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cardiomyopathy					20 years
U	e executed sian and urial-transit	l = I	that initiated events resulting in death) Last C. Due to (or as a consequence of	:				
200	physic the bi	edic	d					
Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3			23d. Date of o	lelivery Day Year
P.0	that th	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	w requires that is been signed k	ted k	History of gastrointestinal bleedi	ng, histor	cy of	1 🗌 Yes	s 2 🗆 No 3 🗔	Probably 4 🛣 Unknown
Division of Vital Records, P.O.	he law red te has be age 2 sho	Completed	severe anemia			24a, Was an autopsy perform 1  Yes 2	prior to led? death'	autopsy findings available completion of cause of eas 2 \square No
tal F	sian: T ertifica ector, p	Bec	25. Was case referred to medical examiner?		Place of Death (Chec			rea shiving
Ţ	Physia this c	은	1  Yes 2 No 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Tir	patient 3 □ DOA		ome 5 Residen	nce 6 Other (Sp	ecify)
0 U	nd <b>ing</b> ath. :: After e fune	cate		ury wo	ork? ☐ Yes 2 ☐ No	254. 20001120 11011	, injury document	
Divisio	To the Hospital or Attending Physician: The law within 24 burusr after death.  To the Funeral Director Atter this certificate has completed filled in by the funeral director, page 2.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, offic	е	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	e Hospita n 24 hours e Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, do only one) 1 Certifying Nurse Practioner: To the best of my knowledge, do only one) 1 Certifying Nurse Practioner: To the best of my knowledge, do only one) 1 Certifying Nurse Practioner: To the best of my knowledge, do only one) 1 Certifying Nurse Practioner: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of my knowledge, do only one) 1 Certifying Physician: To the best of examination and/or	investigation, in my op	inion, death occurred a	at the time, date and	place, and due to th	e cause(s) and manner stated.
_	To the	-	29b. Signature and title of certifier	29c. Lice	nse number	29	ld. Date signed (Mo	nth, Day, Year)
	T		Allowy imp		53MDCRNP	1	May 26, 2	010
			30. Name and address of person who completed cause of death (Item 23a) (The Babette Pennay, CRNP 15225 Shady G		#130 Rock	ville, M	D 20850	
	Sta	te	31. Date filed Wooth, Day Year 010 32. Registrar's Signature	entrol.				

0	W.			ype or Print in					_	ile.
			. 101	State of Maryla				lental Hy	giene	0 0000
			State Registrar		Cer	tificate of D	eath		Reg. No. 🚄 📗	0 8652
	Dhysisia	_,	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
	Physicia Medic		Mary E. Kenny					May 25	, 2010 <sup>*</sup>	4:33 P M
patriops.	Examin		4a. Facility Name (if not institution, give stre	eet a <i>nd number</i> )		4b. City, Town, or	ocation of Death		4c. County of	Death
-	8		Ginger Cove Commun	ity Retireme	ent Cent	ter	Annapo]	lis	Anne A	Arundel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9 v. Year)	Birthplace (State or Foreign Country)
	Director		203-01-3704	91	Yrs.			(Month, Day 12/31/	1918	Pennsylvania
	d sow tt	_	Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Loc	ration				10d. Inside City Limits
	nylan I-f sh ied a	5	Maryland   Anne Arun		ity, lowing co		apolis			1 ☐ Yes 2 🔀 No
	e Ma r 28a notif	Oire	10e. Street and Number			10f. Zip Code		Т	40 - 02	
	ith th	La	8210 River Cresce:	nt Drive			21401		10g. Citizen of Wha	USA
	ath w	Funeral Director	11. Marital Status	. Was Decedent Ever in U	18 113 1/	Vas Decedent of His	nanic Origin? (Spe	cify Yes or No-	14 Boss	American Indian,
	or deg	by F	1 Never Married 2 X Married	Armed Forces?  1 XYes 2 No	.o. 10. V	Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)		White, etc.
33	s afte al", c Exan	g p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates. 43-7	78 1	Yes 2 No	Specify:		Specify:	White
Ö	hours natur ical	Completed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Busir	ness Industry
75	n 72 s. an "r Med	g	(Specify only highest grade Elementary/Seconday (0-12)	Completed) College (1-4 or 5+)	(Give A	rind of work done du O NOT use retired)	iring most of worki	ng		
21	withi giene er th , the	ပိ	Elementary, described (6 12)	4	of:	ficer			US Nav	Υ
р	filed al Hy d oth vent	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
<u>/a</u>	d be Menta	욘	Robert V. Glover				Elizar	eth Tre	exter	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 'is marked other than "natural", or items 2a or 28a-f sho 'is umatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type,	,	19b. Mailin	g Address (Street ar	nd Number or Rura	l Route Numbe	r, City or Town, State	e, Zip Code)
	and 2 s Health em 27		John R. Kenny, Jr.	- Husband	8210	River Cre	escent Dr	, Annar	colis, MD	21401
ore.	- 5 E C		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re		Place of Dispos	sition (Name of natory or other place	,)	Date	20c. Location - Ci	ty or Town, State
Ĕ	Page nent o ant: If ury or		4 Donation 5 Other (Specify)	Ba		e Cremato		//2010	Baltimo	ore, MD
Baltimore,	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee		22	. Name and Address	of Facility JC	hn M. I	aylor Fur	neral Home
			Myelin 1. Vilob	ent		47 Duke o	of Glouce	ster St	, Annapo	lis, MD 21401
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the dea	ath. Do not ente	r the mode of dying	, such as cardiac c	r respiratory an	rest,	Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	Failure	to 1	Thrive				Onset and Death
-	Medical		resulting in death) a.	Due to (or as a consec	quence of):	, 1				
	Examiner	_	Sequentially list conditions, b.	Advance	d V	ementi	7			2 years
	_ +	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	cuted	хап	Cause (Disease or iinjury that initiated events c.						<u></u>	
	be executed sician and burial-transit	cal E	resulting in death) Last	Due to (or as a consec	quence of):					
9	nte be hysic he bu		d.							
Box 6876	eath certificate b attending physi I for use as the b	Physician/Medi	IF FEMALE:	15						
×	th ce ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregr	tal death 3 🗌				23d. Date of Month	
	the at	sic	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	death 5∟	Other (specify)			Wichti	Day Tou
P.O.	that the dec ned by the a detached i	된	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the u	nderlyina cause aive	en in Part I.	23e Did to	nbacco use contribu	ite to the cause of death?
	res th signe	l by			3	, 3		1 🗆		☐ Probably 4 ☐ Unknown
rds	require been si should I	etec								
00	law r has b e 2 st	Completed						24a. Was autor	osy pric	re autopsy findings available or to completion of cause of ath?
Re	sician: The la certificate ha irector, page?		1					1 Yes		Yes 2 No
ta	ician sertifi ector	Be	25. Was case referred to medical examiner?	pital:		26. Pla	ce of Death (Check			
$\leq$	Physi this c	<u>ا</u>	1 Yes 2 No	1 Inpatient 2		t 3 ⊔ DOA	4 Ai Nursing Ho		dence 6 Other	Specify)
0	ling F	ate	1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?		28d. Describe h	ow injury occurred	
<u>i</u>	ttend death tor: /	titio	2 Accident Investigation 3 □ Suicide 6 □ Could not be	OO Disconfinite Ak	ama faum obus		′es 2 □ No	000 1 11 10		Don't Don't Alimbar
Division of Vital Records,	or A after Direc in by	Certificate:	4  Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	et, lactory, office		City or Tow		or Rural Route Number,
	Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physical filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physicia	an: To the best of my know	wledge death o	occured at the time	data and place, an	d due to the ca	use(s) and manner a	as stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Examiner	On the basis of examination of the basis of the basis of the basis of the bast	on and/or invest	igation, in my opinior	n, death occurred at	the time, date a	and place, and due to	the cause(s) and manner stated.
	ro the vithin 2 Fo the comple	Σ	29b. Signature and title of certifier	ractioner: to the best of	ny knowledge, c	29c. License	number	e, and due to the	29d. Date signed (A	Month, Day, Year)
	F S F O		1 Mars 1/2	Da/M/	2	000	2957	7/	05/2	6/2010
			30. Name and address of person who com	pleted ourse of death (Ite	m 23a) (Twne P	rint)	1.2		0-/-	-/
11	TINH		Paul B. Bere	z MD 2	225 F	Defe	nse H	wy,	crofto	M. MD21114
	Stat	е	31. Date filed (Month, Day, Year) A 2 7 2016	32. Pegistrar's Sign	ature.			. //		the cause(s) and manner stated.  er as stated.  Month, Day, Year)  6 / 2 0 / 0  0 M, M D 2 / 1 / 1 +
	Registra		MAY 2 7 2010	Down	A. 16	und				
	riogiotri									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9<sup>Day</sup> 2010<sup>Year</sup> Ellsworth Abbits Kenealy 8:02 A M Medical 4a. Facilify Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 313 Maryland Ave. Westernport 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth Funeral Country) West Virginia 1**√2√**M 2 □ F Months Days OCT. T. 1922 Hours Min. Director 234-26-9565 87 Usual Residence of Decedent 28a-f show 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Westernport 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 313 Maryland Ave. 21562 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married white should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 🌣 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Brakeman unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Kenealy Rhoda Chaney permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
313 Maryland Ave, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) Patricia Kenealy/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/12/2010 Westernport, Maryland St. Peters Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ☐ Yes ned by the g \ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 been signe should be 1 Tyes J No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No malnu 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After Natural Accident 5 Pending work? s after death.

I Director: Aft
of in by the fur 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Directornial Completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Dedical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Dr. N. A. Ranjithan, 517 E. Oldtown Rd., Cumberland, MD 32 Registrar's Signature

30. Name and address of person who commetted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 1 0 2010

1841

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 925 Doris Jean Kline  $\mathbf{Q}_{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours April 5,1934 1 □ M 2 🗓 F 215-34-3800 Maryland Director 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13402 Highland St. 21742 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel Weller Grove Rhea O. Poole Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Jackson-daughter 17808 Walker Circle Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Welty Church of the Brethren Cemetery 1 X Burial 2 Cremation 3 Removal from State 6-5-2010 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 22. Name and Address of Facility Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this it in by the funeral director 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident 2 Accider
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign ature 00 tho completed cause of death (Item 23a) (Type, Prin

Registrar

State

			Plea  1 - For State Registrar	se Type or Pr State of N		d / Depa	<b>delible ink.</b> artment of H r <i>tificate of L</i>	lealth a	•	Hygie	_	ible.	8655
The state of the s	Physici /Medio	cal	1. Decedent's Name (First, Middle Ruth Helen Kir 4a. Facility Name (If not institution	kwood	27)		4b. City, Town, or	Location of	2. Date of Month May	Death 30	Day 201		3. Time of Death 12:07 AM
a parties and the second	Examir Funeral	ier	Homewood at Wi	lliamsport	Age (In yrs. I	last birthday)	Williams  If Under 1 Year  Months Days		4 Hrs   0 Date of	Birth Day, Yo	Washi	ngtor	County  Dlace (State or Foreign try)
	Director show	ır	213-20-7147  Usual Residence of Decedent  10a. State  10b. County  Maryland Washir			Yrs. y, Town or Lo			Nov.	22,	1921 	Mary	Land  Od. Inside City Limits  1 □ Yes 2 No
	3a or 28a-f	Funeral Director	10e. Street and Number 16505 Virginia		Wl	lliams	10f, Zip Code 21795			10g	. Citizen of		
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Modical Exemitism that it is recitified at		11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force ied 1X1Yes 2E If Yes, Give - Year or Date:	s? P943-		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	ispanic Orig in, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	Bla	ce - Americ ck, White, e fy: Whi	etc.
21215-0036	filed within 72 h Hygiene. ther than "natu snt, II s Moule	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	College (1-4o	or 5+)	16a. Dece (Give life. Homen	dent's Usual Occupi kind of work done o DO NOT use retired naker	luring most		P		al Re	esidence
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Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		Al Kirkwood-so  20a. Method of Disposition  1 Burial 2 Decremation  4 Donation 5 Other (S)	3 ☐ Removal from Sta		lace of Dispo emetery, crer thsbur	Seepsake Institution (Name of place of	e) ory 6	Date -1-2010	Sm	c. Location	- City or To	wn, State Maryland
Balt	Departi Departi Importa any Inji	_	21. Signature of Funeral Service	A Fox	iy	1	2. Name and Address .331 Easte	ern Bl	vd. North	n Ha	gerst		MD 21742
760,	American executed with social provided in the prival-transit prival pri	lical Examiner	shock, or head failure. List immediate Cause (Final disease or condition resulting in death)  sit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b.	as a consequas a consequas a consequ	uence of):			DEMENTO		,		Approximate hielyal Between protein and peath
O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcor 1   □ Live birtl 4   □ Pregnan 9   □ Unknow	n 2 ☐ Fetal tat time of d	I death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	у		_		ate of deliver	ery Day Year
cords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant condition	ons contributing to death $TMACF(B)$	n but not resu	ulting in the u	nderlying cause give	en in Part I.	1	id tobac □ Yes Vas an	2 100	3 ☐ Prot	he cause of death?  bably 4 Unknow
Vital Records,	ician: The lav certificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?	sac					a	utopsy erforme	d?	prior to co death? 1 ☐ Yes	mpletion of cause of
Division of \	ding Phys n. After this funeral dii	Certification: To	27. Manner of Death  1 Netural 5 Pendin, investig 3 Suicide 4 Homicide 6 Could r determ	28a. Date of I (Month, a	njury Day, Year)	28b. Time o Injury	Work	4 ⊌ Nur	28f. Location	be how	injury occu	rred	fy) al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifyin 2 Medical	g Physician: To the be Examiner: On the basis	s of examina	wledge, deat tion and/or in	h occurred at the tir evestigation, in my o	pinion, deat	d place, and due to h occurred at the ti	me, date	and place	, and due to	stated. o the cause(s)  Day, Year)
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	Sta Registr		31. Date filed (Month, Day, Year)	77/VCN M 2 2010 32. Regi	strar's Signa	ture	bace	110/	U THEG	470	WN,	W C	1146
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DHMH 17 Rev 1/2001

10-04224 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Candice Kane State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Medical Examiner** 1415 hrs June 3, 2010 Candice Lee Kane 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 622 Pinehurst Street Harford **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Wignington Delaware Months Days Hours Director 2 X F 222-54-7226 1 M 35 08/31/1974 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 No or items 23a or 28a-f shormust be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygienc. Maryland Harford Aberdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 622 Pinehurst Street <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White, etc. 2XX No Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dialysis Technician Medica1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be Raymond McNatt <u>Caroline</u> Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print.) nt: If item 27 is more other traumatic e 205 West Mover Drive, Edward Davis / Uncle Bear, <u>Delaware</u> 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State crematory or other place) June 10, 4 Donation 5 Other Specify <u> Mayerdale Crematory</u> 2010 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East. <u>Maryland21901</u> Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Wedical Death a Methadone intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed sician/Medical tending physician a use as the burial -X UNPENDED AMENDED 23a,27,28a-f.per ME g905 7/13/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? signed by the attending be detached for use as t Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 1 Yes 2 No 9 V Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, After this certificate has been in the state of the state 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA 1 Yes 2 No 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 1 Yes 2 X No 5 Pending Fd 2:08 pm Fd 6/3/10 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State 022 Pinenurst St Aberdeen, MD 6 X Could not be 3 Suicide residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. June 4, 2010 Drame 6

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Legistrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

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	for State Registrar			<b>,</b>	•		e of E			,	Reg. N	20	10	3	857
icion/		me (First, Middle, L	,							2. Date of De Month		Day	Year	3. Tim	e of Death
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	20a. Method of Di 1  Burial 4  Donatio		Removal from State	cen	ce of Dispos netery, crem ro Cre	atory or	other plac	e) INC	May	2010			nore,	Town, Stat MD	e
	21. Signature of	oneral Service Lice	ensee		Bã 49	rran 5 Go	dAddes V. R	sons itchi	e Hw	A. Seve	erna	Par Par	k Fu k, M	neral D 211	Home 46
/ I		ert fallure. List only e (Final tion	mplications that caused one cause on each line.  aa	a consequer	nce of):	f;	لمنرا	144		or respiratory a	rrest,				imate Between and Death
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þ	Part II. Other sign	nificant conditions	contributing to death b	out not result	ting in the u	nderlying	cause giv	en in Part	I.					the cause	of death?
Completed										24a. Was	an	24b	. Were au	topsy findir	ngs available of cause of
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Be	25. Was case refe examiner? 1 \sum Yes 2	rred to medical	Hospital:				Othe	er.	/	k only one)					-
e: To	27. Manner of Dea	ath	28a. Date of inju		8b. Time of		28c. Injury	/ at		ome 5 Resi 28d. Describe				ify)	
ertificate:	1 Natural 2 Accident			y, rear)	injury	М	work 1 🗆	Yes 2	] No						
ျပ	3 Suicide 4 Homicide	6 Could no determine		ury - At hom c. <i>(Specify)</i>	e, farm, stre	et, factor	y, office			28f. Location ( City or To			ber or Ru	ral Route N	lumber,
Medical	29a. Certifier (Check only one)	2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	examination a	ind/or invest	igation, in	my opinio	n, death o	ccurred a	t the time, date	and pla	ce, and d	ue to the	cause(s) and	d manner stated
2	29b. Signature an	4	Jo i radioner. To the			-	c. License	number		, and do to te	29d. [	Date sign	ed (Monti	h, Day, Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ 02:55A M MADELINE LaCURTS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal WICOMICO Hospice at the If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F MARYLAND Months Days Hours Year) Director 218-20-8310 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MARYLAND WICOMICO WILLARDS 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 35602 TINGLE ROAD 21874 USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GARMENT ASSISTANT any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (UNKNOWN) TRIITTT BEATRICE BAKER permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALD LaCURTS/SON 35588 TINGLE ROAD, WILLARDS, MARYLAND 21874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETHEL CEMETERY 6/2/10 WILLARDS, MARYLAND Fureral Service Licen 21. Sign ture 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DISTEASE END STACE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to joi as a consequence on sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2-7 9 🗌 Unknown Records, P.O. certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes Yes director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 KNo Hospital: HOSPICIZ 10 1 Inpatient 2 ER/Outpatient 3 DOA o 24 hours after death.

e Funeral Director: After this leted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Data 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Frantioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the name(s) and manner stated Cartifying Nurse Frantioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Frantioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Frantioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Frantioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Frantioner: To the basis of the cause (s) and the basis of the cause (s) and the basis of examination and of the basis of examination and of the basis of the cause (s) and the basis of the basis of examination and of the basis of the (Check within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHUMAN 33 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		irtment <i>tificat</i> e			and M	lental Hy	giene Reg. No.	010	8659
	Physicia	n/	1. Decedent's Name (First, Middle, Last	<i>'</i>							Date of De     Month	ath	Year	3. Time of Death
	Medic Examin	al	Fenton Virgil Lowe 4a. Facility Name (if not institution, give				4b. City, To	own. or I	Location	of Death	MAY	4, Day 20	10 unty of Dea	15:30 M
	) Examin	CI	WMHS - REGIONAL M		NTER		CUME	BERLA					LEGAN	
	Funeral Director		216-40-2963	x <b>X</b> M 2 □ F 7. Age	(In yrs. last 68	birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da DeC • 3	th ', Year 941	g. Bir Mar	thplace (State or Foreign Yland
	and show lat	or	Usual Residence of Decedent  10a. State 10b. County	Т	10c. City, T	own or Loc	ation							10d. Inside City Limits
	Maryl 28a-f otifiec	irect	MD Garrett		Gran	tsvil	le							1 🗌 Yes 2 🔀 No
	vith the 23a or st be n	Funeral Director	10e. Street and Number 12028 National Pi	ke			10f. Zip (	536				10g. Citizer USA	of What Co	ountry?
	leath v	Fune	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V			panic Ori	gin? (Spec	cify Yes or No- Rican, etc.)	14.		erican Indian,
30	after o	d by	1 Never Married 2 X Married . 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 If Yes, Give	No	1	Yes 2				iloan, etc.)	- 1-	Black, Whit	<sub>e, etc.</sub> Vhite
2	hours natura dical E	olete	15. Decedent's Ed (Specify only highest gra		1	16a, Deced	ent's Usual ind of work	Occupat	tion	t of workin			of Business	Industry
9500-61212	thin 72 ene. than "	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DO	) NOT use r	etired)	ining mos	t of workir	ig		ett Co s Dena	ounty artment
ם א	filed wi Il Hygie I other vent, t	Be	17. Father's Name (First, Middle, Last)			HUDOL	<u> </u>	T	18. Moth	er's Name	(First, Middle,			II CIRCITO
Maryland	lid be i Menta narked	To	Charles Lowery								latter			
Z	Ith and Ith and 27 is n		19a. Informant's Name/Relationship (Ty) Sharon A. Lowery/				-				Route Number	-		o Code) 1536
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆		20b. Plac	e of Dispos	sition (Name	of	- !		ate			Town, State
Ĕ	it. Page rtment rtant: I njury o		4 Donation 5 Other (Specify	)		tinge	c Ceme	eter	у Ма		2010			
g	Depa Impo any i		21. Signature of Funeral Service License	man							man Fur tsville		Homes. 21536	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused		Do not ente	r the mode	of dying,	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	hysician/ Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	4/+1	Sy	skm	0.	50	7~	fai 14	rc		Onset and Death
	Examiner			St	consequent	ce of):								24 184-5
	p ts	dical Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	Curiscylleri	Ca Jij.	110							24 Harry 5
	ate be executed hysician and the burial-transit	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	Consequen		110							Janey S
2	te be e nysiciar ne buria	dical	L	d										
00	ertifical ding ph	/Me	IF FEMALE:	23c. If yes, outcome o	of pregnancy	,								
X	eath ce atten d for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at	2 Fetal de	eath 3 🗌	Ectopic pre Other (spec					23d	Date of de Month	livery Day Year
	it the d I by the stacher	Phys	g Unknown  Part II. Other significant conditions co	9 Unknown	rt not reculti	ng in the ur	dorlying on	uno divo	n in Part		00- Did			the cause of death?
λ, T	ires than i signed	Completed by	DINBELLS, Commercy	erosis,	H	1011	ter	510	14	·· 	1			robably 4 Unknown
ecords,	w requast beer 2 shou	plete	DIABELES, C	hrome	c ol	554	uch	1/2			24a. Was		4b. Were au	topsy findings available completion of cause of
ř	: The la			VILLE,	CU	-ill	Ung	0,	DE &	My	perfo	ormed?	death?	s 2 No
<u> </u>	sician: certifi irector	To Be	25. Was case referred to medical examiner?  1  Yes 2 100	lospital:	· 0 🗆 = 5	VO. 1		Othor		th (Check				***
5	ng Phy ter this neral d		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,	y 28	b. Time of injury		c. Injury a work?	at		ne 5 Resident 8d. Describe			ity)
VISION	ttendir death. :tor: Af r the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				M database	1 🗆 Y	′es 2 □	_	205 1 1' 1			
Š	al or A s after al Direct ed in by		4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.		s, iaiii, siie	et, factory, t	onice			City or Tov		mber or Hu	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1 Certifying Physical Examination only one) 2 Medical Examination only one) 3 Certifying Nursi	er: On the basis of ex	amination an	nd/or investi	gation, in my	y opinion	, death oc	curred at 1	the time, date a	and place, and	due to the	cause(s) and manner stated.
	To the To the Comp	2	29b. Signature and title of certifier	Ala.	Dest Of thy Kil	lowleage, a		_icense r		and place		29d. Date si	ned (Monti	h, Dav. Year)
			Wow h					D53	3158			may	16	2010
		10	30. Name and address of person who co STASKO, MICHAEL W	· ·	,	, , , , ,	,	CUI	MBERI	LAND.	MD 21	502		
	Stat		31. Date filed (Month, Day, Year)  MAY 0 7 201	32 Registra			اري							
	Registra		MAI U / 201	(Aliens	A.	Marie					-			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:23 A Physician/ Mayor 28 2010 Day Mary Helen Ledford Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death St. Mary S Leonardtown 22680 Cedar Lane If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 - M 2 - F Months Days Hours Min. 62 March, 2ª, 1948 Vifgiffia Director 212-56-0588 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director St. Mary's Leonardtown Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20650 22680 Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 😿 No If Yes, Give Year or Dates Specify. White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 N Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma Della Elizabeth Hale Maiden Surname) ဂ္ Walter Fred Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen Sue Miller/ daughter 12246 Catalina Drive Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of Waters Memorial Cenetery June 3 2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Leonard Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. RD. Port Republic, MD Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrest Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the bunal-transit Sleep Apnea Due to (or as a consequence of): resulting in death) Last Physician/Medical COPD Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 2 C To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 **N**O Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Shah MD 22650 Cedar Lane Ct. Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 0 2 2010

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

LAGUNAS-FITTA

HOSPITAL

3001

32. Registrar's Signature

29d, Date signed (Month, Day, Year)

Physician Charles David Lockhart  Charles David Lockhart  4. Februage Supplies and the physician of the phys	10-04077 Charles David Lock	thart State	e of Maryland / Depa	ndelible Ink. Ensure All Cop artment of Health and Mental I rtificate of Death	Hygiene 20	0 i866
4a. Facility Name (if not institution, give stored and number)  Founded  Fo	Physician/	1. Decedent's Name (First, Middle,L	ast)	timeate of Boats	Date of Death     Month Day Year	
Trunctor   Continue	( )	4a. Facility Name (if not institution,	give street and number)		th 4c. County of Dea	th
The State   The		5. Social Security Number 6.	Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year If Under 24H  Months Days Hours M	· · · · · · · · · · · · · · · · ·	Control of the Contro
3   3   Wildowed   4   Observed   New Year   1   Yes   2   No specify   Spec	vland -f show any once. tor	10a. State 10b. County MD Prince		ollege Park		10d. Inside City Limits 1 Yes 2 No
3   3   Wildowed   4   Observed   New Year   1   Yes   2   No specify   Spec	th the Mary 23a or 28a notified at	9352 Cherry Hil		20740	U.S.A.	
Physician (Medical Jaminer  Ph	after death wi rall", or items incr must he by Funera	3 VVIdowed 4 XIDIVOIG	ed Armed Forces?  1 X Yes 2 No ed If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer  1 Yes 2 No specify:	to Rican, etc.) White, etc. Specify:	hite
Physician (Medical Jaminer  Ph	1036 rithin 72 hours ene. rr than "natur Medical Exam	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use re	etired)	s/Industry
Physician (Medical Jaminer  Ph	1215-0 1 be filed wental Hygic arter other other went, the Be Co	Charles S. Loc	khart	Carol	E. Gilchrist	
Physician (Medical Jaminer  Ph	MD 2's bould alth and Ms and 27 is maxin control of 17 is maxin cont	John Lockhart/B	rother	530 Maple Way, Lush	ру, MD 20657	
Physician (Medical Jaminer  Ph	ltimore, it. Pages 1 an trient of Hea ortant: If ite y or other tri	1 Burial 2 XCremation 4 Donation 5 Other Spec	Removal from State Le	crematory or other place) ee Crematory 06/	04/2010 Clinton,	MD
failure List only one cause on each line.    First and Lists are condition resulting in death		Ma M. Mounts	.M	8125 Southern Md	Blvd., Owings, MD	20736
Sequence of the cause of the property of the	/Medical	failure. List only one cause on Immediate Cause (Final disease	each line. a. <b>Atherosceroti</b>	ic cardiovascular dise		Between Onset and
AMENDED    Text    Kaminer	Sequentially list conditions.	Due to (or as a consequence of c.				
Female   Part	oe executed cian and irial - transi			or ME 0904 6/28/10 TT		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?	Box 68760 death certificate I he attending phys of for use as the bh nysician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal death 3 Ectopic pregr		
24a. Was an autopsy performed?  1	, P.O. I res that the signed by t be detached by PP	Part II. Other significant condition	s contributing to death but not re	esulting in the underlying cause given in Part I.		
25. Was case referred to medical examiner?  1	Records The law requirent has been page 2 should				autopsy prior to performed? death?	completion of cause of
27. Manner of Death   27. Manner of Death   28c. Injury at Work?   28c. Injury at Work?   28d. Describe how injury occurred   28d. Describ	Vital ysician: his certif director, o Be	examiner?	Hospital: 1 Inpatient 2	Othor		er: Scene
28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	ion of Viending Ph. eath. or: After ti	27. Manner of Death  1 X Natural 5 Pending	(Month, Day,Year)		28d. Describe how injury occurred	
29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated	Divisi pital or Ati surs after de eral Direct illled in by	3 Suicide 6 Could no	ot be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc.		Rural Route Number, City
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day Year)	To the Hosy within 24 ho To the Fund completely f	(Check only one) 2 ✓ Medical Examin	er:On the basis of examination ar			

30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) JUN-9

OCME

Mol

29c. License number

O.C.M.E.

May 29, 2010

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fo Amend#18, 19 Aper FH State of Maryland / Department of Health and Mental Hygiene State Registrar 6/2/2010 AACO HEALTH DEPT CMH Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 Day 20 JAMES MATTHEWS 11:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UHIVERSITY OF MARYLAND MEDICAL CENTE N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8 Date of Birth 1**X** M 2 □ F Hours May 2th, 9 y, 12963 Months 201-58-9026 C6Trorado Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Odenton 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 675 Old Waugh Chapel Rd. 21113 USA items ; 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or itel dical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: Specify: 3 Widowed 4 Divorced Black Completed Year or Dates. 1984-87 other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department College (1-4 or 5+) Elementary/Seconday (0-12) 12th Police Veteran Affairs 0 Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o and 2 should be fill Health and Mental tem 27 is marked ဂ္ James Matthews Sr Emma Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Matthews (Mother) 675 Old Waugh Chapel Rd. Odenton, Md. 21113 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Rest Cemeterv 5-27-10 Hanover, Md. Signature of Funeral Service Licenses W Mame Race Cof Mollit Sons Mortuary, P.A. 821 West St. Annapolis, Md. M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NONISCHEMIC cardiomyopathic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CONGENITAL HEART DISEASE Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) certificate be executed APRHUTHMIA burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown g Unknown To the Hospital or Attending Physician: The raw required within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES Completed 1 Yes 2 No 3 Probably 4 Onknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Bacchus, MD 1336374321 May 20, 2010

Registrar

State

22 SOUTH GREENESTREET, BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

RAFEEHA BACCHUS

MAY 2

7

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Month Debra K. Moore 22 May 6:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 0874071954 North Carolina Director 215-62-3424 55 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 965 Fall Ridge Way 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give marked other than "natural", 3 Divorced 4 Divorced Specify. White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor Parishable Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ဂ Jimmy Eugene Harris Mabel Joyce Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is r permit. Page 1 and 2 sh Department of Health al Important: If item 27 is Thomas E. Moore/Spouse 965 Fall Ridge Way, Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 5/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland 21. Signature Fu eral Service Licensee 22. Name and Address of Facility Beall Funeral Home any 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) real. Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Dause (Disease or imjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year been signed by the same should be detached 9 Unknown Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2  $\square$  No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 2 Touse 4 Nursing Home 5 Residence 6 NOther Spec 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: Natural 5 Pending Investigation injury n 24 hours after death. Ie Funeral Director; A bleted filled in by the fi 2 🗆 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052830 her 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) stook Road #300, Anneasis, MD

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

18665

	•	For State Registrar	State of Marylan		artment of He tificate of D			giene – U	1 0	10000
Physicia		1. Decedent's Name (First, Middle, L	MC FariAL	JD			2. Date of Dea Month	th Pay	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, gi	ive street and number)		4b. City, Town, or L		<del>- (/5</del>	4c. County		
Funeral Director		5. Social Security Number 6. 343–20–6677	Sex 1 M 2 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day 10/	1		lace (State or Foreign
Maryland Ba-f show tified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's Bow	y, Town or Lo	cation				10	0d. Inside City Limits 1   Yes 2   No
n with the N is 23a or 2 nust be no	Funeral Director	10e. Street and Number 3800 Enfield Cha	se Court #316		10f. Zip Code 2071	6		10g. Citizen of W		ry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. 1951-	1	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🏋 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e Bla	tc.
ithin 72 hou ene. r <b>than "natu</b> t <b>he Medical</b>	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		(Give I life. D	dent's Usual Occupat kind of work done du O NOT use retired) .stered Nu	ring most of worki	ing	16b. Kind of Bu		ustry
d be filed w Mental Hygi arked other tric event, t	To Be	17. Father's Name (First, Middle, Last William McFarla	•	8		18. Mother's Name Fannie	_		)	
and 2 shoult Health and I Im 27 is ma her traums		19a. Informant's Name/Relationship  Gerald A. Perez/	Son	14016	ng Address (Street and Old Stag	e Road,	Bowie,	Maryland	20	720
nit. Page 1 a artment of H ortant: If ite injury or ot		20a. Method of Disposition  1	Removal from State Tri	emetery cren nity E rch Ce	sition (Name of patary or other place, PISCOPAL emetery !. Name and Address	6/5/		Bowie, M	lary1	and
permi Depar Impo any ir		Joseph +	quil	1	.6000 Anna	polis Ro	ad, Bow	ie, Mary		20715
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ple	Myeli Myeli	such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death Mowific
sate be executed physician and the burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to for as a consequence.  Due to for as a consequence.	,						
ate be e hysiciar the buria	edical		<b>d</b>						_	
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ O 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	ry Day Year
uires that th in signed by uld be detac	ed by Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.				e cause of death?
The law req	Completed by						24a. Was a autop perfor 1  Yes	sy p med? d		sy findings available npletion of cause of 2  No
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death, within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Certificate: To Be	25. Was case referred to medical examiner?  1  Yes 2  Vo  27. Manner of Death  1  Accident	(Month, Day, Year)	28b. Time of injury	Others  28c. Injury a work?  M 1 7	4 □ Nursing Ho	me 5 Resid 28d. Describe ho	ence 6 Dother	d	MANDRIN
spital or At nours after o neral Direct I filled in by		4 Homicide determine		)			City or Tow			
the Hos ithin 24 h the Fur ompleted	Medical	(Check 2 Medical Exa	miner: On the basis of examination urse Practioner: To the best of my	and/or invest	tigation, in my opinion	, death occurred at time, date and place	the time, date ar e, and due to the	nd place, and due cause(s) and mar	to the caus	se(s) and manner stated. ted.
<b>₩</b> 2		30/ Name and address of person who	completed cause of post (Item	23a) (Type, P	> D4	4838		29d. Date signed	25	10 21401
Stat		SUSAN H,	KRIEGER 2010 32. Projector's Signate	ure	445	Deter	18 H	wy Xu	1 Nay	orlis, MI)
Registra	ır	202	Lever ,	B. A	ares					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Amend #8,per FD, CCHD, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6/4/10, drw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year McC Love lary 06 0006 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min Director 217-26-0559 80 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 1 □ Yes 2√∑ No Director MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12255 Catalina Drive 20657 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Modis once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emerson Dunbar Audra Clella Harbert ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12255 Catalina Drive, Lusby, Maryland 20657 Nancy Tinsley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 6-4-10 Leonardtown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Low disease or condition resulting in death) /Medical Du to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) P.0. detached 9 T Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performe certificate ev 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Iniury death. 1 ☐ Yes 2 ☐ No investigation Director: d in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 ف 2010 D006178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang Choi, MD 100 Hospital Drive, Prince Frederick, Maryland 20678 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUN - 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 26<sup>Day</sup> Barbara Moyers 201<sup>rear</sup> 9:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House / Montgomery Hospice Montgomery Derwood Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🛛 Hours (Month, Day, Year) 10, 1938 Virginia |218-34-7038 71 Director Nov. Usual Residence of Decedent works Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s er must be notified 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10218 Nolan Drive 20850 United States "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Intelligence Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reed Lawrence Miller Anna Lorraine Repass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Sandifer / Cousin 113 Waterway Drive, Ocean View, DE 19970 Department of Heali Important; If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park Cemetery 20a, Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, Deer Park Drive, STUVER 1RACYA 20111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Peritoneal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 26, 2010

Registrar
DHMH 17 Rev 7/2009

State

Diane Ruckert , CRNP, 6001 Muncaster Mill Road, Derwood , MD 20855

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, J. Martin June 2010 5:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Wilson Health Care Center Montgomery Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours June 18, 578-34-9965 81 **Director** 1928 California Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" "" any injury or other traumatic events." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Gaithersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 311 Russell Avenue #237 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Powell Helen Sowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Martin, Son 110 Fairgrove Terrace, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cematery, crematory or other place)
Metropolitan
Crematory 1 Burial 2 K Cremation 3 Removal from State May 27, 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Devol Funeral Home, f Funeral pervice Lic nse 21. Signature 22. Name and Address of Facility M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. 23a. Part Interval Between Immediate Cause (Final disease or condition year and Death Ph sician/ Dementia Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying ed by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Unknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No After this certificate 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 😾 No 1 Tyes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury Investigation 1 Yes 2 No Accident M Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and tittoof certifier 29c, License number D20148 May 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue, Gaithersburg, MD 20877 Steven Dolinsky, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William James Year Macker 8.00 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery 5. Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) PA 1**X** M 2 □ F Months Days Hours Min Marchay4 Year) 1925 204-12-3879 85 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Bethesda 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9908 Edward Avenue 20814 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White 1943-45 Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Systems Dispatcher Electric Utility permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Macker Catherine Flatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Macker/Wife 9908 Edward Avenue, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date May 2010 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD Signature of Funeral Service Licen 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Dementia Onset and Death Physician/ advanced Medical resulting in death) Due to (or as a consequence of): Examiner Failure 00 Sequentially list conditions, Due to for es a nonscouence en cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury ithin 24 hours after death.

the Funeral Director; Afortpleted filled in by the fun Accident Investigation Suiciae
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F 3 only one)

100

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

30. Name and address of person who co

Pinky Singh, MD

State Registrar

oleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

6502 Kenilworth Avenue, Riverdale, MD 20737

20057458

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #5 Per FH G912 2/01/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Geraldine Harris McInnis 2:10 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham 5. Social Security Number 3 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 8, 1950 **Funeral** 9. Birthplace (State or Foreign DC Country) Days Hours Min. 60 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State should be filed within 72 hours after death with the Maryland must be notified at Director 10c. City. Town or Location 10d. Inside City Limits Prince George' MD Bowie 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13003 Belle Meade Trace 20720 U.S.A. ı "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced ind Mental Dysection "natural is marked other than "natural is marked other the Medical E Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other tha ury or other traumatic event, the I College (1-4 or 5+) CEO-Pastor 4 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Harris Bethenia Bullock 19a. Informant's Name/Relationship (Type, Print) 13003 Belle Meade Trace, Bowie, MD Larry T. McInnis-Husband 20720 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lincoln Cem 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State permit. Page Department o Important: If any injury or Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2010 21. Signatur uneral Service Licensee 22. Name and Address of Facility DL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Washington DC 20020 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Kespirotory Medical Due to (or a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မြ 1 Inpatient 2 K ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) ame and address of person who ted cause of death (Item 23a) (Type, Print) 20106 R. Omolara 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JUN 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, 2010 Dona1d Edward McMillian 7:07 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral**  Birthplace (State or Foreign Country)
 DC 1 🖾 M 2 🗆 F Months Days March 6, Year) 953 577-72-5490 Director 57 DC Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Montgomery Village 1 X Yes 2 □ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 19503 Divot Place ould be filed within 72 hours after death ond Mental Hygiene.

marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces Black, White, etc.
Black 1 X Never Married 2 Married Completed by 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Private Be .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Corrie Gist Lonnie Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Talisha Wynn/ Daughter 20886 19503 Divot Place Montgomery Village, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place ☐ Donation 5 ☐ Other (Specify) Harmony Landover, Maryland 21. Sic e of Funeral Service 2. Name and Address of Facility Stewart Funeral Home, Inc. NE Washington, DC 20019 4001 Benning Rd. NE 23a. Part Deter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to lor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 2 🗌 No Yes 2 🗡 completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Menner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 🗌 Yes Accident Investigation 2 🔲 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number 29d. Date sig

Registrar
DHMH 17 Rev 7/2009

State

d address of person, who completed cause of death (Item 23a) (Type, Print)

10-04269		Please Type or Print in Black Indelible Ink, Ensure All Copie	es Are L	egible.	1 18572
William Otero Nie	ve	1. For State Amend 13&14 per FD.	lygiene	2011	10016
Physician	n/	Registrar DOR, 6/8/10, LDB Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of De	eath	3. Time of Death
Medical Examine	er	William Otero Nieves	Month June 4, 2		1725 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Easton Memorial Hospital  Easton	1	4c. County of D	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s, 8. Date of E	Birth(MM/DD/YYYY) 9.	
Director		584-04-4540 1 Mm 2 F 43 Yrs. Months Days Hours Min	May	10,1967 0	Country), Rico
<u> </u>	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	/	IP	10d. Inside City Limits
d d d					1 Ves 2 No
arylan	Director	MD Caroline Denton  10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?
the M	- 1	221 N. 3rd Street 21629		2151	7
72 hours after death with the Maryland n"natural", or items 23a or 28a-f show all Examiner must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		lo- 14. Race - Ar White, etc	merican Indian, Black,
er dea	-1	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Pue:		Poer	to Rican
ours aft		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	an Specify: W	
6 172 hc	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)		
5-0036 led within 7 Hygiene. I other than	<u>ا</u>	5 Never Workeo  17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Surname)	1e
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Headth and Mental Hygiers (ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	~			•	
2121 nould be fill d Mental F is marked tic event, I		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I			
MD and 2 sho alth and 27 is raumat	1	ROSa Nieves 221 N. 3rd Street  20a. Method of Disposition (Name of cemetery)	Dent	on, Mary	land 21629
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	1	1 V Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City	or rown, State
Baltimos permit. Pag Department Important: injury or ot	4	4 Donation 5 Other Specify: Portacoeri Cemetery 6  21. Signature of Funeral Service Licensee 22. Name and Address of Ficility	10/10	Bayamon	, PuertoRico
Balti permit. Departm Imports injury o	1	21. Signature of Funeral Service Licensee  22. Name and Address of Ficility  Henry Funeral  5 10 washington	Home,	P. A.	MD.21613
Physician		23a. Par I. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as a rdiac of failure. List only one cause on each line.			Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a Cardiac arrhythmia			Death
		or condition resulting in death)  Due to (or as a consequence of):  Dilated cardiomyopathy			
1		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ed nsit Examiner		(Disease or injury that initiated events resulting in death). Last			
and and tra		d			
O, ebe ex sician burial		AMENDED AMENDED line a-b, 27, per ME g905 7/15/	10 TT		
Box 68760, re death certificate be ex the attending physician red for use as the burial thysician/Medic	2	IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy		23d. Date of deliv Month	very Day Year
Box 6 e death cel the attendiced for use	3	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  9 Unknown	***		
D. B( t the de by the sached fi		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
s, P.O. ires that the signed by the detach			1 Ye	s 2 No 3 P	robably 4 🗹 Unknown
Records,  The law requires ficate has been sig. page 2 should be			24a. Was		autopsy findings available to completion of cause of
Recc The lav cate ha	5			ormed? death	?
Division of Vital Records, at all or Attending Physician: The law requirers after death.  Tal Director: After this certificate has been a led in by the funeral director, page 2 should the prification: To Be Completed		25. Was case referred to medical examiner?	only one)	harman .	
f Vi Physic er this real dir	2	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA  Other4 Nursin  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?		Residence 6 Oth	her:
Division o spital or Attending hours after death.  Inertal Director: Aft affiled in by the function:  Certification:	[	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	20d. Describe	now injury occurred	
Divisior pital or Attend ours after death neral Director: filled in by the	3	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
Dir Hospital of 24 hours a Funeral It		4 Homicide determined (Specify)	or Town,		20
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be extending Physician: The law requires that the death certificate be extended the funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial redical Certification: To Be Completed by Physician/Medic	5	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and constant 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To the Ho within 24 To the Fu completely	2	and manner stated.  29b. Signature and title of certifier  29c. License number	amo, date	29d. Date signed (A	
,		O.C.M.E.		June 5, 2010	, ,, ,
_ \	1	30. Name and address of person who completed cause of death (Item 23a)			
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
State Registra	~	31. Date filed (Manth DayYer) 2010 37 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28 d,e,f per ME G904 6/30/10 TT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1:50 PM Jerry Owens JR 2010 mau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ★ M 2 □ F Days Hours Months Month, Pay, Year, 3/1/1957 MASS 53 Director 213-76-3572 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 🛠 🔽 No MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 310 Constant Ave. 21144 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Student Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ oe i Sally Fasano Jerry Allen Owens Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl-Department of Health ar Important: If item 27 is any injury or other trau Father 310 Constant Ave. Severn, MD 21144 Jerry Owens Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial ② Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/26/2010 | Glen Burnie, Md Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Licensee Annapolis, MD 2140 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ CERTIFICATION APPROVED BY WESTCAL EXAMINES Aspiration of: Food Bolus disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the bunal-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Year Pregnant at time of death Month ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to <u>ک</u> Seizure disorder 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available Schizophrenia 24a. Was an autopsy performed?
Yes 2 X No prior to completion of cause of death? cate has page 2 s Obesity the Hospital or Attending Physician: The 1 Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ¥ Yes 2 □ No 2 1 Inpatient 2 ER/Outpatient 3XXDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil 28b. Time of 2:30 28c. Injury at work? 28d. Describe how injury occurred subject choked on food unknown 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 5 Pending pm Division 1 ☐ Yes 2 🙀 No 5/21/2010 approx. 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1620 Chitton St 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined group home facility unknown Baltimore, MD Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion, and at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one 29b. Signature and litle of certifie 29d. Date signed (Month, Day, Year) 29c. License number may 21, 2010 00066212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy MCClosky, MD 201 East University ause of death (Item 23a) (Type, Print) 201 East University Parkway - Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2010 Registrar

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / Dep	rtificate of Death		leg. No.	18674
Physic	ian	1. Decedent's Name (First, Middle, Lest)		2. Date of Dea Month	Day Year	3. Time of Death
/Med		Mary Jane O'Brian	1 4 60 7	May	31 2010	8:55 A <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, give street and number)  20711 Breezewood Dr.	4b. City, Town, or Location of Death		4c. County of Death	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Hagerstown If Under 1 Year   If Under 24 Hrs.	8 Date of Birth		
Funera Directo		199-24-6106 1□ M 2 X F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day Dec. 24	Year) Cou	nplace (State or Foreign Intry) NSylvania
		Usual Residence of Decedent		Dec. 2-	+,1701   1 CIII	13y I Valita
yland		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
a-f.s	ctor	Maryland Washington County Hagerstow	n			1 □Yes 2 No
th the	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Cou	untry?
23a	ra [	20711 Breezewood Dr.	21742		U.S.A.	
r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼NO	1 ☐ Yes 2 🎇 No Specify:			ite
hours tural		3 ▼Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business/I	
in 72 in 72 in 72	plet	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing		
with jiene	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 6 Teac	her		Church Nurs	ery School
other went,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
Lail y facility & I.K. I.S. 10000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, Ite Medical Examinat must be notified at	10	Harold Franklin Fetherman	Beatrice	Vogel	Fetherman	
and land land land land land land land l			ng Address (Street and Number or Ru			ïp Code)
and 2 lealth m 27 I			2 Shea Lane Gaithe			
es 1		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition  20th Place of Disposition	osition (Name of matory or other place) sh Mem. Park 6-5-2	Date	20c. Location - City or 1	own, State
Pages ment of ant: If its ury or o		+ Bonation o Bother (openity)			Ambler, PA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Moolcal Examiner must be rediffed at any one.			2. Name and Address of Facility Do			
		- Company of the second	331 Eastern Blvd.			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	11 Cominon	ح		4411
/Medical		Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
ted	nin	Sequentially list conditions, if any, leading to immediate cause. Linter Uniderlying Cause (Disease or injury				
execu	Examiner	that initiated events c				
rificate be executed gphysician and as the burial-transit	cal	d d				
g phy g phy as the	edical					
eath cert attending		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□ Fete-ie niegnone.		23d. Date of deli	ivery
deat deat de atte	icia	1 Ves 2 Mio 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
at the de by the tached	Physician/N	9 Unknown				
res that	by F	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.		bacco use contribute to	
w requires been signatured is				1 🗆 Y	es 2⊿No 3□Pr	obably 4 🗌 Unknown
law r las be	Completed			24a. Was a	sv prior to o	topsy findings available completion of cause of
sician: The certificate h	Con			perfor	med? death? 2 No 1 ☐ Yes	2  No
ician: The	Be	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only or	ne)	
_ × .s. p	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			lence 6 Other (Spec	cify)
ding Ph h. After th funeral	ino.	27. Mann of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	Work?	28d. Describe h	ow injury occurred	
tend death tor:	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm st	M 1 Tyes 2 No	20f Location /6	Name of Advantage of Po	um l Danska Musinbas
or A after a Direc	Certification:	4 Homicide	reet, lactory, office	City or Tow	Street and Number or Ru n, State)	rai noute ivalliber,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	, and due to the	cause(s) and manner as	s stated.
n 24 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time,	date and place, and due	to the cause(s)
To the vithi	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	
SYP		Muskey heland	D4166	7	6.1.1	0
		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		11	o han mo
/ 		Michael McCorneck  31. Date filed (Month, Day, Year)  32. Jagistrar's Signature,	1110 Medies	com	rus losse	span M)
Regis	tate trar	JUN 0.2 2010	hands!			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of I	Marylan	nd / Depa	artment rtificate	of H	lealth a	and M		iene ()	0	18675
į	Physic		Decedent's Name (First, Middle, Grace	Obiageli	00	dibo					2. Date of Dea May 15		Year	3. Time of Death 0432 M
1	/Medi Examir		4a. Facility Name (If not institution, Gilchrist Hos		er)			fown, or	Location of	of Death		4c. Count	of Death	
	Funeral Director		5. Social Security Number  NONE  Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2式 F	Age (In yrs. 47	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Dec. 7,	, Year)		place (State or Foreign intry) g <b>eria</b>
	ne Maryland Ba-f show Milled at	Director	Md. 10b. County Howar	d		y, Town or La								10d. Inside City Limits 1 X Yess 2 □ No
	th with the	al Dire	10e. Street and Number 5021 Rome Red	Way			10f. Zip (	Code L043			1	og. Citizen of Nige 1		intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Exam har must be notified at anone.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force at 1 Yes 2 If Yes, Give Year or Date	is? ⊒No		Was Decede if Yes, speci		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	Bla	ck, White,	
Maryland 21215-0036	I within 72 ho iene. r than "netur the Madical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give life.	dent's Usual kind of word DO NOT use rofess	done d	ation during mos	t of workin	og .	16b. Kind of B	usiness/Ir	
/land	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, L Tobi Iloanya	ast)		4	20				(First, Middle, inwurah	Maiden Sumai	ne)	
Mary	od 2 sho Ith and ! 27 Is me		19a. Informant's Name/Relationshi Dilim Iloanya	ip (Type, Print) (Brot	her)		Rome				Route Number		. ,	21043
Baltimore,	Pages 1 ar		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (See	3 □Removal from Sta	20b. P	Place of Dispo cemetery, crem mily Co	sition (Nam	e of her place	9)	Da		20c. Location	City or T	own, State
Balti	permit. Departn Importe any inju		21. Signatury of Funeral Service	endy C	002	57 W		3ach 14Eh	n Fur	eral			gton,	DC 20010
a a	Physician /Medical		23a. Part 1 Enter the disease, or or shoot, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	aMelano			er the mode	of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death years
	Examiner  ian and  rial-transit	Examiner	Sequentially list conditions, and leaves. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dualto (or a	as a consequ	uence of):								
O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	d	2 Fetal	Ideath 3□	Ectopic pre						te of deliv	ery Day Year
rds, P.	w requires that been signed by should be deta	þ	Part fl. Other significant condition	s contributing to death	but not resu	ulting in the ur	nderlying ca	use give	n in Part I.					the cause of death?
		Completed					<del>,</del> -			_	24a. Was a autops perform	y ned?	Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of 27 No
	ystcien: Th	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatien	t 3 DQA	Othe			(Check only on		er (Speci	6.)
Division of	ding Pt h. After tt funeral		27. Manner of Death  1 XNatural 5 Pending 2 Accident investiga	28a. Date of fr (Month, L		28b. Time of Injury		c. Injury Work		2	8d. Describe ho			Mospice
DIX	To the Hospitei or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	building,	etc. (Specify	/)					City or Towr	i, State)		al Route Number,
	To the Hospitei within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 ★ Certifying (Check only one)	Physician: To the best kaminer: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred a restigation, i	t the tim n my op	e, date and inion, deat	d place, ar th occurre	nd due to the ca d at the time, d	ause(s) and mate and place,	anner as s and due t	stated. to the cause(s)
			29b. Signal fre and title of certifier	lus				License	number 58	303	}	9d. Date signe	d (Month, 27	Day, Year) ZO(D
	3		30. Name and address of person with AAROW J C	ho completed cause of	67	OIN.	Char	265	ST	7	ani dun	MO		
	Sta Registra	.e	31. Date filed (Month, Day, Year) <b>JUN 0 2 2010</b>	Server 32. Regis	strar's Signal	ares								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathleen Marie O'Dea Month May 2010 5:30 Medical A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 603 Hillsmere Drive Anne Arundel Annapolis cial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 579-34-2769 Year) 927 Months 1 M 2XXX 82 Washington DC Director Usual Residence of Deceden 28a-f shov 10b. County 10a, State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2 X No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. items 23a Funeral 603 Hillsmere Drive 21403 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ō þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. tant; If item 27 is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Timothy Hanlon Kathleen Hever 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
33 Hillsmere Drive Annapolis, Maryland 21403 Joseph P. O'Dea/husband 603 Hillsmere Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. Hillcrést Mém. Gardens 5/28/2010 Annapolis, Maryland 4 Donation 5 Other (Specify) neral ge ce Licensee 22. Name and Address of Facility John M. Taylor Funeral Home <u>147 Duke of Gloucester St., Annapolis, MD 21401</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ e to (or sa cons quence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a ensequence of): Examin Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialthe attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ P in the past 12 months? Month Pregnant at time of death Yes 2 Do 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 2010 encu. Name and address of person who completed cause of death (Item 23a) (Type, Print) Detende Highlese State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:00 PM 05-26 -2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Coloniai North East eci 9. Birthplace (State or Foreign Country) India 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 136-86-103 62 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director North 10e. Street and Number 10g. Citizen of What Country? Col India Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer 17. Father's Name (First, Middle, Last) 18-Mother's Name (First, Middle, Maiden Surname) shatam Kasiben ate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Colonial North East, MD 21901 Circle 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Services J-27-10/11/2 000.

22. Name and Address of Facility Family Funeral Home

Strang of Feckey Family Funeral Home

Are Area of 21. Signature of Femeral Service Licensee 19702 one 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC LUNG CARCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, It any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ DIABETES MELLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No r this certificate h 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P.V. Naya N. MD 05/23/10 D0065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 A. E. MAH STREET FLKPN MD NARAYANA RAD. U. PULA 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 1 2018 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year  $\mathbf{P}^{\mathsf{M}}$ Medical Rossi Larry May 0 5:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillside Assisted Living Howard Clarksville Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) Director 193-10-3627 92 1918 Pennsylvania Usual Residence of Decedent Show or 28a-f shov notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a o or other traumatic event, the Medical Examiner must be Funeral 8010 Old Montgomery Rd. 21043 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
X Yes 2 \( \subseteq \) No Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give WWII Year or Date WWII Specify: White 1 Tes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. ant: If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Electrical Engineer Electronics Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Marino Rossi Erselia (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Larry Matthew Rossi/son 8014 Old Montgomery Rd. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once, cemetery, crematory or other place, 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Journey Crematory 05/29/10 | Woodbine, MD 21. Sign re of Funeral Service Going Home cremation Service P.O. Box 784 PM01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause reisease or impry Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impory that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No. 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medica 26. Place of Death (Check only one) assisted Hospital 1 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 N Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? ë 1 X Natural injury 5 Pending Certifical 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica 29a, Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) May 28, 2010 D47447 MD

State Registrar

AV,

oted cause of death (Item 23a) (Type, Print) 6334 Cedar Lane Columbia, MD 21044

parke

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rson who comple

Andrew Lazris, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> **Physician** Month May 31 James Thomas Rees, Jr. 1:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kline House Mount Airy Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Vear) Days Hours 1 XM 2 ☐ F 74 315–32–5799 Indiana 1936 Feb 8, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6125 L Springwater Place Completed by Funeral 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ByYes 2 No If Yes, Give Year or Dates: 1958–61 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchandise Manager Retai] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thomas Rees, Sr. Thelma Marie ဂ္ Marguand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lee Rees/wife 6125 L Springwater Place Frederick, Maryland 21701 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Final Journey Crematory 6/2/2010 Woodbine, Maryland 21. Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 stural thomas 23a. Part I, enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) embo Dulmonar ue to (or as a consequence of): cerebra 6 MOLL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): COTONAT a Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760

burial-tra attending physician for use as the hirial the signed by t been has After this certificate s after death.

I Director: After this
of in by the funeral d within 24 hours a To the Funeral D

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.

"natural",

al Hygiene.

f Health and Mental Item 27 is marked o

permit. Pages 1 Department of H Important: If ite any injury or ot

**Physician** 

/Medical

Examiner

Pages 1

item 27

the Medical

Baltimore, Maryland 21215-0036

							1 □Yes 2 No	1 ☐Yes 2 ☐No
25. Was case refer examiner?	red to medical				26.	Place of Deat	h (Check only one)	
1 Yes 2 X	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	B □ DOA	Other: 4	☐ Nursing Ho	ome 5 Residence	6 Nother (Specify) HOSPICE
27. Manner of Deat  1 X Natural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury	28i	lc. Injury at Work? 1 □Yes		28d. Describe how injury	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, street,	factory,	office		28f. Location (Street an City or Town, State,	d Number or Rural Route Number, )
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin	owledge, death ocation and/or invest	curred a igation, i	t the time, d in my opinio	late and place n, death occur	, and due to the cause(s) rred at the time, date and	) and manner as stated. I place, and due to the cause(s)

29b. Signature and title of cortifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print 9093

State Registrar

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5+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2010 Andrew Eliot June 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6517 80th Street Montgomery Cabin John . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign . 1922 1 🕅 M 2 □ F Aug 29 Massachusetts Director 390–16–8788 87 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 🗌 Yes 2 😾 No Maryland Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6517 80th Street 20818 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates:1942-46 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Executive Non-Profit Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Gorham Rice Rosamond Eliot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Bergfors Rice/wife Cabin John, 6517 80th Street Maryland 20818 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/3/2010 Woodbine, Maryland Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 1 stinse Thomas M00957 MD 21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Heratocellular disease or condition Cancer years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) Exami Cause (Disease or iinjury that the death certificate be executed and trans that initiated events resulting in death) Last Due to (or as a consequence of) g physician a street purial-Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 \_\_ Live Birth 2 \_\_ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Pregnant at time of death Unknown 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 **X**No 2 🗌 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D43083 June 2, 2010

15 H

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar DHMH 17 Rev 7/2009

State

George A.

acke

9707 Medical Center DRive #300 Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sotos, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 6:03 rodise 0 2010 /Medical 4a. Facility Name (If n t institution, give street and number) 4b. City, Town, 4c. County of Death **Examiner**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Numbe **Funeral** Year) 1 □ M 2 X F Months Days Min Yrs. MD 05/22/1945 Director 219-44-0704 64 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hyglene.

arked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov 1XYes 2 □ No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Tuscawalla Street 21550 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2√☐No Specify.White 3 Widowed 4 Divorced er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important; If item 27 is marked ot any injury or other traumatic ever ပ Bertha Walters Harry Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Rishell/Husband 311 Tuscawalla Street Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens 05/13/2010 Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21. Signature of Funeral Service Licenses 21 N. Second Street Oakland, MD 21550 Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DSIS DE /Medical Due to (or as y consequence of): Examiner CV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (in the cause of the Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death detached 9 Unknown 9 Unknown een signed by the should be detached Part II. Other significant conditions contribiting to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certilicate has autopsy performed? Yes 2 1 No or Attending Physicians The 2 □ No 1 □Yes 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¥Z Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

Year

MAY 1 1 2010

completed cause of death (Item 23a) (Type,

32 Registrar's Signature

			For State Registrar	State of M	aryland		artment of rtificate o			lental Hy	giene	)   0	18682
			1. Decedent's Name (First, Middle, I	Last)						2. Date of D	eath		3. Time of Death
77	Physici /Medi		Ethelwyn Bla	nche Rile	ey					Month May	13,	Year 2010	1:48 P.M
and the same	Examir		4a. Facility Name (If not institution, g	give street and number	7)		4b. City, Town	, or Location of	of Death	-	4c. Co	ounty of Death	
			Garrett County				0ak1a				Ga	arrett	
п	Funeral			. Sex 7. A 1 □ M 2 🛣 F	ge (In yrs. la		If Under 1 Yea Months Day		24 Hrs. Min.	<ol><li>Date of Bi (Month, D)</li></ol>	ay, Year)	9. Birth	place (State or Foreign intry)
	Director		215-42-4733 Usual Residence of Decedent		88	Yrs.				10/27	/1921	Mar	yland
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	h the Maryland r 28a-f show	ţo	MD Garre	ott	Oa.	kland							1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		J Oa	Kiana	10f. Zip Code	•			10g. Citizer	n of What Cou	intry?
	leath with	a D	394 Audley Rile	v Rd.			21550	0			Unite	ed Stat	es
	ter deatl Items 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	. 13.	Was Decedent of		igin? (Spe	ecify Yes or N		Race - Amer	ican Indian,
Maryland 21215-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show Ideal Evaning must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2X  If Yes, Give  Year or Dates:	No		if Yes, specify Cu 1 □ Yes 2 🛣N			Rican, etc.)		Black, White,	etc. i <b>ite</b>
9-0	2 hou	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occ	upation			16b. Kind	of Business/Ir	
215		ple	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	(Give life.	kind of work don DO NOT use reti	ne during mos red)	t of worki	ng			
21	d wit	Son	12			wor	ker				Baus	ch & L	omb
pu	2 should be filed within 72 ho and Mental Hygiene. is marked other than "natur aumatic event, I'm Mudical	Be	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle	e, Maiden Su	rname)	
yla	ould be f Mental   arked of atic eve	မ	William Otto					Lei	na El	llen Gr	oves		
lar	2 sho		19a. Informant's Name/Relationship	(Type. Print)			ng Address (Stre						ip Code)
رن ح	and dealth m 27 her t		Reece Riley, So	on			Audley						
lore	ges 1 It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other p	lace)		ate	20c. Locat	tion - City or T	own, State
ij	t. Partmentant:		4 ☐ Donation 5 ☐ Other (Spec	cify)		berla	nd Crema	tory	05/1	4/2010	Cumb	erland	, MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mente Important: If item 27 is marked any injury or other traumatic enonce.		21. Signature of Funeral Service Lic	Sweitzer		22	Name and Add David A 21 N. Se	ress of Facilit Burde econd	ock I	Funeral Oaklar	L Home	, P.A. 21550	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications the cause	d the death.								Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. A Cuu Due to (or as	TE		CEARD	IAL	TN	FARC	TUN	/	Onset and Death
		ē	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b.	я в вопанция	indu of):						-	<del></del>
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	an an ial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):							
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9	rtifica ng ph as th	ledi									- 1		
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal o	death 3	Ectopic pregna Other (specify)				230	I. Date of deliv	very Day Year
σ.	that ned b deta		Part II. Other significant conditions	contributing to death I	but not result	ting in the ur	nderlying cause o	given in Part I.		23e. Did	tobacco use	contribute to	the cause of death?
rds	luires n sigr iid be	d b	HOUTE GA	STROINT	25T1	NAL	- BLS	EED a	rtic	1 🗆	Yes 2⊠i	No 3□ Pro	bably 4 🗆 Unknown
of Vital Records,	w rec s bee shou	Completed by	ANEMI	4			•		,	24a. Was	an 2	24h Were aut	opsy findings available
Re	he law e has ige 2 s	m C	ANDIO	A	-					auto	opsy ormed? 22 No	prior to co	ompletion of cause of
ta	in: T ifficat or, pa		25. Was case referred to medical	<del></del>								1 □ Yes	2 🗆 No
S	s cer lirect	o Be	examiner?	Hospital:	ient 2 🗆 E	P/Outpotion	. 2000	thar:		(Check only		7.045 /G	
	a Phy er this eral c	Ë	27. Manner of Death	28a. Date of Inj	ury 2	28b. Time of				ne 5 ⊔ Hes 28d. Describe		Other (Speci ccurred	ity)
Division	th. :: Aft	Certification: To	1 Natural 5 ☐ Pending investigati	( <i>Month, D</i> a	ay, Year)	Injury		ork? □Yes 2 🔲 !	No				
<u>Visi</u>	Atter r dea ector by the	Ë	3 ☐ Suicide 6 ☐ Could not	d 28e. Place of in	jury - At hom	ne, farm, stre	eet, factory, office	9	2			lumber or Rur	al Route Number,
Ö	al or after a state of in l	ert	4 ☐ Homicide determine	building, e	tc. (Specify)				- 10	City or To	wn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier Check only one) 1 Certifying I	Physician: To the best aminer: On the basis and manner si	of examination	ledge, death on and/or in	n occurred at the vestigation, in my	time, date an	nd place, ath occurr	and due to the	e cause(s) ar , date and pla	nd manner as ace, and due t	stated. to the cause(s)
	To the within 2 To the сотрые	Me	29b. Signature and title of certifier	1.				nse number	1 -			igned (Month,	Day, Year)
			Butter	Murch	M	D	d	227	- 2	05	05	/13/	2010
		/	30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type,	Print)			05 ND,			
		Q	KARL E. SU	twALM.	311 1	N. 4	IM 57	DA	KLA	ND,	MD	215	50
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 4 20	32 Regist	rar's Signatu	re	New York			/			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2810 1. Pauline Elfrieda 9:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Solomons Nursing Center Solomons Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Germany **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours 1 M 2 M F 11/23/1920 214-30-2668 Director 89 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 1 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12838 Homestead Lane 20657 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 👺 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 To No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates id Mental Hygiene. marked other than "natur matic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools <u>Cafeteria Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be 1 Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic ev Georg Karl Holder Maria Speidel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Rose, III/ Husband 12838 Homestead Lane, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 & Cremation 3 Removal from State Metropolitan Crematory 06/05/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ FAILURE TO THRIVE EN VICEKS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) cause, Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours and Cause (Disease or linjury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death
Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 N Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗄 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D36969 June 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11910 H.G Trueman Road, Lusby, Maryland 20657 Scaria Mathew, MD Date filed (Month, Day, Year) 32. Registrar's Signature State -2 2010 Registrar

18684

			For State Registrar		Ce	rtificate of L	Death		Reg. No.				
	Physicia	n/	Decedent's Name (First, Middle, Last)     EDWIN RIVERA					2. Date of Dea	25 <sup>Day</sup> 2010	Year	3. Time of Death		
	Medic Examin	ai	4a. Facility Name (if not institution, give street and nun	nber)		4b. City, Town, or	Location of Death		4c. County of Death		11:43 PM		
-1			NATIONAL NAVAL MEDICA				BETHESDA MONTO						
ı	Funeral Director		5. Social Security Number 041-80-7802 6. Sex. 1 M 2 $\square$ F	7. Age (In yrs, la 28	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti May 10,	rth 9. Birthplace (State or Foreign country) CT				
	ryland -f show ied at	ctor	Usual Residence of Decedent		, Town or L					10	0d. Inside City Limits		
	he Ma or 28a e notif	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
	h with 1 1s 23a nust b	Funeral Director	390 Willetts Avenue			06385			USA				
036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Giv Year or Div	edent Ever in U.S rces? $^2 \square$ No $^2$ 00 re $^2$ 01 ates.	)2 <b>-</b> I	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 X Yes 2 No Specify: Puerto Rican				e - America k, White, e White	tc.		
212-(	in 72 hou e. han "natu Medica	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business II		ustry		
21	ed withi Hygiene other th	Be Co	12 17. Father's Name (First, Middle, Last)			Soldier	18 Mother's Nam	ne /Firet Middle	US Ar				
/lan	ould be file nd Mental marked c matic eve	뎯	Ceferino Rivera			other's Name (First, Middle, Maiden Surname) adys M. Adames							
, Man	1 and 2 should be of Health and Mente fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print) Yesenia M. Rivera/Wife			ing Address (Street a					ode)		
Baltimore, Maryland 21215-0036	permit. Page 1 ar Department of H Important: If ite any injury or oth		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State C	emetery, cre	osition (Name of ematory or other place Cemetery	e) 6/	Date 5/10	20c. Location -				
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Licenses  Marian J	l. Arlin	gton,	VA 22203							
	6		23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on ear	caused the death	n. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death		
Ŧ	Priysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  BLAST INJURIES OF THE HEAD  Due to (or as a consequence of):										
	Examiner	<u>.</u>	Sequentially list conditions, b.							_			
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury										
	tificate be executed ng physician and as the burial-transit	al Ex	that initiated events resulting in death) Last C. Due to	or as a consequ	ence of):								
9/8	ificate b ng physicas the b	Medical	d			-4-				$\perp$			
Box 65		Physician/N	F FEMALE: 23b. Was decedent pregnant   23c. If yes, out   1	e of delive nth	ry Day Year								
л. О	that th gned by e detac	by Ph	Part II. Other significant conditions contributing to d	eath but not res	ulting in the	underlying cause giv	en in Part I.				e cause of death?		
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Yeco	The law rate has b	Completed							rmed?	rior to con leath?	sy findings available inpletion of cause of		
ta Ta	cian: Tertifica	Be	25. Was case referred to medical examiner?				ace of Death (Chec	77					
<u>&gt;</u>	g Physi or this c eral din	e: To	27. Manner of Death 28a. Date	Inpatient 2  of injury	28b. Time o	of 28c. Injury	4 ∐ Nursing H ⁄ at		ence 6 Othe				
ono	tending eath. or; Afte the fun	Certificate:		th, Day, Year) 0 2010	7:20	P M 1 x	? Yes 2□No	WEAPON	ATTACK				
Division of Vital Records,	tal or Att rs after d al Direct ed in by i		4 🗔 Homicido determined 28e. Place	of Injury - At ho ng, etc. (Specify	)	reet, factory, office O HAQ	9	28f. Location (S City or Tow	treet and Numbe n, State) AFG	HANI:			
	Hospi 24 hou Funer leted fill	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the base only one) 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner:	sis of examination	and/or inve	stigation, in my opinio	on, death occurred a	at the time, date a	nd place, and due	to the cau	se(s) and manner stated.		
_	To the within To the compl	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mr.								ay, Year)		
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	Stat Registra		31. Date filed (Month Day Year)  JUN 0 2 2010 Server 32. R	egistyr's Sign	il.								

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:43PM Physician/ Dorothy Lee Ruck 71106 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Ye ctober 3, g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Maryland 1 □ M 2X□ F Months Days Hours 76 220-30-9435 October Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nothers". 10a. State 10c. City, Town or Location Director 1 XYes 2 No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 11 West Baltimore Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kershner Mary Catherine Fryer Cecil Max 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 West Baltimore Street, Hagerstown, Maryland 21740 James P. Ruck 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06-14-10 Hagerstown, Maryland Rose Hill Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. hoel Brady 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Uriner Physician/ disease or condition resulting in death) Medical **Examiner** UT Sequentially list conditions, Due to or as a consequence of): Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Obstructive pulmoney disease 1 Probably 4 Unknown Completed acute rend feilure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Drebetes Mellitus 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2-E/No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-0054413 10/10 30 Name and address of parson who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

A. MARCA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathleen McDonough Reuter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS Allegany Cumberland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) PA 1 □ M 2 □ F Hours Oct 15 Director 159-22-5434 82 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1715 Bedford Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ 1 Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matthew McDonough Mary (Munroe) McDonough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1715 Bedford Street Cumberland MD 19a. Informant's Name/Relationship (Type, Print) MD 21502 Amv Reuter daughte Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20c. Location - City or Town, State 1 🗡 Burial 2 🗌 Cremation 3 🗌 Removal from State 6/8/2010 Flintstone MD 4 Donation 5 Other (Specify) 21. Signature of eral Service 22. Name and Address of Facility Part Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final UNG CONCER Physician/ disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last ettending physician or use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) the 9 Unknown 9 Unknown to the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🔲 No 3 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Watural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year)
06 (06 / 10 29b. Signatur certifie D50844 30. Name and address completed cause of death (Item 23a) (Type, Print) 912 SITTON DIEIVE OWN BETWAND MD 21501 WHILATR 31. Date filed Month. D State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Shirley Marie Spiker 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland Western Maryland Regional Medical Center If Under 24 Hrs. Hours Min. g. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) December 31, 1936 If Under 1 Year 7. Age (In yrs. last birthday) Maryland Social Security Number Days **Funeral** 1 M 2 AF 73 214-34-1657 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County **Funeral Director** 1 X Yes 2 ☐ No Midland Allegany Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21542 14801 Railroad Street, Apt. I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Mantal Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☑ No 1 X Never Married 2 Married ģ 1 ☐ Yes 2 🗹 No White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Home Cook 0 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Ruth Eleanor Gallagher ည William Harrison Spiker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13215 Upper Georges Creek Road SW, Frostburg, Maryland, 21532 Ruth Crawford - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 13, 20a. Method of Disposition 1 🗡 Burial 2 🗆 Cremation 3 🗀 Removal from State Frostburg, Maryland Frostburg Memorial Park 2010 4 Donation 5 Other (Specify) Eichhorn-McKenzie Funeral Home P.A 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Pato .Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated avents. Examiner attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Month Day in the past 12 months? after death. Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 2 1 No 1 🗌 Yes 욘 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide completed filled in by 4 Homicide determined 124 hour. The Funeral D' Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) To the within 2 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria Coun OAKI GALLE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 6. Sek 1 1 M 2 □ 8. Date of Birth 9. Birthplace (State or Foreign 233-42-9527 Hours Days (Month, Day, Year) 4/9/1929 Country) Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or forther traumatic event, the Medical Examiner must be notified at any injury or forther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Preston Terra Alta 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 254 26764 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Miner Coa1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reed Shaffer Opal Teets Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy McCrobie/Daughter 180 Morgan Mine Rd, Reedsville, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Terra Alta Cemetery 5/14/2010 Terra Alta, WV 21. Signature of Funeral Service Licensee <sup>22.</sup> Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta 26764 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complica-Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Year 9 Unknown Division of Vital Records, P.O. eath but not resul g in the underlying cause given in Part I. as been signed I 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed Jas page 2 🗆 No 1 Yes Vas case referred to examiner? 26. Place of Death (Check only one) Be 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 Yes 2 No atural 5 Pending Accident Investigation the 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cay

31. Date filed (Month, Day

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of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 8am Doris Laverne Stevens Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Arunde1 Anne Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 M 2x5xF Hours Min. (Month Pay 1943 Country) Director 214-40-9502 67 Md Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10d. Inside City Limits Director 1 Yes 2XX No MD Anne Arundel Crownsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1164 St. Stephens Church Rd. 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes ※X No Black, White, etc. <u>Ş</u> 1 Never Married 2 Married If Yes, Give 1 Yes XX No Specify: White Completed 3x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Realtor** Real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon May Anita Henning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean Stevens 1621 Seward Rd. Chester, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial XX Cremation 3 ☐ Removal from State 5/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Md 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Savice Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Ent the disea Part 1. Ent. the disea 4, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on , ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARDIAL disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) 5 Guer tally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires in 24 hours after death.

Lemeral Director, After this certificate has been sign better filled in by the funeral director, page 2 should be reted filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed PERLIPDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

68760 Box ( P.O. Records, **Division of Vital** e Funeral C

Baltimore, Maryland 21215-0036

completed To the within 2 To the F State Registrar

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29a. Certifier

(Check

only one)

29b. Signature and title

31. Date filed (Month, Day, Year)

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIMITA TALWAR, 2004 VILLAGE

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00060832

AGEGREEN CROFTON MD 21114

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>20</u>10 4:41 P M Sarah E. Scheele May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 303 Beach Drive Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) av 11,1951 1 □ M 2 🗑 F Months Days Hours Min. Washington.DC 59 Director 579-62-5234 May Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗆 Yes 2 🕅 No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Beach Drive 21403 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Event Planner Event Planning vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Noone Loretta Courneen other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denis J. Scheele/ Husband Annapolis, MD 21403 303 Beach Drive. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date any injury or 1 Burial 2 Toremation 3 Removal from State Kalas Crematory 4 Donation 5 Other (Specify) 5/25/10 Edgewater, Maryland 21. Signatural Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final cell carcinoma of pancicus and gallbladde Physician. a. SMall disease or condition resulting in death) months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events g physician and is the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ending puse as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No page death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of certifie 29d. Date signed (Month, Day, Year, MD D44161 May 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

15

Registrar

State

Pamau Czapp, MO

MAY 2 6 2010

2000 Medical Parkway #670, Annopolis MD 21401

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Charles Hillard SOCKS Physician/ 1113 AM 2019 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Oct. 30 Year) Maryland 1 X M 2 🗆 Months Min. 218-38-1694 68 **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Clear Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14043 Broadfording Road 21722 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify: Specify: Completed 3 UWidowed 4 X Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) self-employed painter 10 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked o Ernest Richard Socks Anna Elizabeth King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie J. Baker - companion 14043 Broadfording Rd., Clear Spring, Md. 21722 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State / injury 6/4/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licens MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi nopera that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the at the detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes N certificate or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Natural Certificate: 28d. Describe how injury occurred 5 Pending 1 $\square$ Yes 2 🗌 No hours after death. Ineral Director: A 2 Accident 3 Suicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

2H-3

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

31 Date filed Month

gistrar's Signature

street, Hagerstown und

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manuel De Jesus Sanchez

		1- For State Registrar			Cei	rtificat	e of L	Death			R	eg. No				
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Funeral		5. Social Security Number	6. <b>Sex</b>	7.	Age (In yrs. I	ast birthd	ay)	If Under 1 Yea		r 24Hrs.	8. Date of Bir	rth (MM	/DD/YYYY)		hplace (State or	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			he de	00	1721	37		47 14th							•	
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/ita sicial is cer	Be	examiner?	Hospit	tal: 1 Inp	atient 2 🗸	ER/Outp	atient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Resid	ence 6	Other	-	_
Phy Fer th	2	1 ✓ Yes 2 No 27. Manner of Death	48	28a Date of	Injune	28b. Tin			ry at Work	? 12	28d. Describe	how in	jury occurre	ed ed		-
ding h. Af	ou	1 Netural	nding	FOUND:	ay,Year)	FOUN		1 1	Yes 2 🗸	No S	Subject sho	ot				
SiO Atter deat ector	cat		estigation	May 28, 20		1419 h		factory, office t		_	28f Location (	Street	and Numbe	er or Rui	ral Route Number, City	-
Division of Vital Records, P.O. Is to Artending Physician: The law requires that the Arten death.  In the Artending Physician: The law requires that the Arten this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	dei	uld not be ermined				, 311000,	ractory, office t	Janaing, et		or Town, \$ 648 Hillside	State)				
spits hours ners	S	4 Momicide			_ocal Stre					- 1						ú
n 24 he Fu he Fu	ca	(Check only						d at the time, di n, in my opinior								П
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  The Funcaral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		and	manner stat				29c. Licens			, ********************************					_
	2	29b Signature and title of certi	7/1	6	1/1/	199	6					29d. Date signed (Month, Day, Year)  May 29, 2010				
	η ΙΙ	(/wb	(gl	and 5	reck	- 10		O.C.	IVI.⊏.			Livia	y 29, 20 	10		
0 9	1	3 Name and address of person			•											
23	H R	Victor Weedn MD JE			cal Exami			nn Street, E	Baltimore	e, MD 2	21201					
	tate	HREEL 43 CD 41617	h	32. Regis	strar's Signat	See R	1									
Regis	124 T	######################################	U Alla	<b>エルドペペーノ</b>	Auf a	·										

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**ORIGINAL** 

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arlton Smith, J	r.	State of 1-For State Registrar	Maryland /		artment o rtificate o			Menta	ΙНу		Reg. No.	20	10	18693	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Carlton		Smit	h .	Jr.			- 1	Date of Dea Month May 30, 2	ath Day	Year		3. Time of Death 0301 hrs	
		4a. Facility Name (if not institution, give st N/B I 495 just north of Ritchie					, Town, or L er Marlb	ocation of D		4c. County of Dea Prince Georg				's	
Funeral Director		5. Social Security Number 6. Sex 1 M M		(In yrs. 1a 29	ast birthday) Yr	Mor	ths Days	If Under 2 Hours	4Hrs. Min.	8. Date of Bi	17,1	980	9. Birth Foreigr Cou	pplace (State or Washington ntry)	
Maryland 28a-f show any 1 at once.	_	Usual Residence of Decedent  10a. State	l l		Town or Loca	tion						-		10d. Inside City Limits 1 X Yes 2 No	
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2506 Darel Drive	#103				Cip Code			1		zen of Wh	at Coun	try?	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral D	11. Marital Status  1 Never Married 2 Married 1	. Was Decedent E Armed Forces?	ver in U.		as Dece /es, spe		Mexican, Pu		cify Yes or No ican, etc.)	0-	White		an Indian, Black,	
)36 thin 72 hours after than "natural", edical Examine	Completed by	3 Widowed 4 Divorced If Y for 15. Decedent's Education (Specify only hard Elementary/Secondary (0-12) 12th	Dates:		16a. Deceder during n	nt's Usu nost of w	al Occupation	on (Give kind DO NOT use	eretire		16b. k	Specify:	iness/In		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natingury or other traumatic event, the Medical Exa	Be	17. Father's Name (First, Middle, Last)  Carlton Smith Sr					18	8.Mother's N	lame (F		Maiden Br	Private  Maiden Surname)  Bryant  aber, City or Town, State, Zip Code)			
MD 27  od 2 should  lith and Me n 27 is ma numatic er	<sup>L</sup>	19a. Informant's Name/Relationship (Type Latisha Ford-Smith	Dai	rel Dr	· #10	3,	Suitla	nd,	MD	2074	46				
Baltimore, permit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State		Place of Dispo- crematory or of Surrect	her plac ion	e) Cemet	ery 0	6/0		Cli	inton	,Mai		
Balt permit Departi Import		21. Signature of Funeral Service Licensee								. Jenk Landov			ra1 2078		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b.											Approximate Interval Between Onset and Death		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a conseq												
be executed sician and urial - transi	edical E														
Ox 6876( leath certificate e attending phys for use as the b	TFFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1										delivery Da	ay Year			
S, P.O. E uires that the d n signed by the	ed by Phy	Part II. Other significant conditions con	ntributing to death t	out not re	esulting in the I	underlyii	ng cause giv	en in Part I.	_	1 Yes	s 2 🗸	No 3	Proba	ne cause of death?	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detailed.	Completed	25 W					2C Plans	f Doobb /Ob		1 Yes	osy rmed?	pr de		opsy findings available impletion of cause of	
Vital Rechapsician: The labsic certificate	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	ı ınpatient		ER/Outpatient		DOA O		ursing l	Home 5		nce 6 🗸		Scene	
ion of tending Ph		27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day Yea May 29, 2010	ir)	28b. Time of 0301 hrs	Injury	28c. Injury	at Work? s 2 ✓ No	Pe	Bd. Describe Bdestrian	struck	by auto			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 4 Homicide	28e. Place of Injur	state/E	express				N/	or Town, S B I 495 Nor	State) th of Ri	itchie Ma	rlboro F	al Route Number, City Rd., Upper Marlboro,	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On	-			tion, in r	ny opinion, o	death occurr			and place	ce, and du	e to the	cause(s)	
	Σ	29b. Signature and title by certifier	To Ve	elle	29c. License number O.C.M.E.  29d. Date signed (Month, Did May 30, 2010					h, Day,Year)					
- 3		30. Name and address of persor who comp Victor Weedn MD JD Assis	tant Medical E	Examin	ier 111 F	Penn S	treet, Ba	ltimore, N	/ID 21	1201					
St Regist	ate	31. Date filed (Month, Day, Year) JUN 0 2 2010	32. Registra s	Signad	eles										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Garfield May 28. R. Sutton 2010 10:20a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 8. Date of Birth Sept. 14, 1939 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**¾** M 2 □ F Crisfield, Md. Director 219-34-3375 70 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4504 Rockdale Ln. 20772 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 XYes 2 No7/1/58 Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 BLack 1 ☐ Yes 2 🗷 No Specify: Year or Dates. 8/24/59 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Rail Transp. Start-up Superv. Metro Area Transit Be 17. Father's Name (First, Middle, Last) ... yidl.
... age 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is marrany injury or other 18. Mother's Name (First, Middle, Maiden Surname) Garfield Sutton Gladys Horsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Burrow-Sutton / Wife 4504 Rockdale Ln. Upper Marlboro, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fields/ Briggs 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State June 5,2010 Stony Creek, Va. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Alexander S. Pope. P.A. Pikė/Porestville, Md 70108 20747 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Intra Abdominal Abscess disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Pancreatic Cancer 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA <u>ا</u> 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) 28 00061937

DHMH 17 Rev 7/2009

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

CANDACE L.U

JUN 0 2 2010

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:20A HELEN ETTA SOLLARS JUNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** CHARLES GENESIS WALDORF CENTER WALDORF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 1 □ M 2 🔀 F Months Hours Min. (Month, Day, Year, MARYLAND 93 Director 216-40-7906 1917 6. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location I fitem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 28a-f sho 10a. State 10b. County Director 1 Tes 2 No WALDORF CHARLES MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U. S. A. 20602 4140 OLD WASHINGTON ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 25 No If Yes, Give Year or Dates. filed within 72 hours after of Hygiene.

d other than "natural", or by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HELEN ETTA ROBEY WILLIAM G. DAVIS should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other tra. 10885 DEMARR ROAD WHITE PLAINS, MD 20695 WILLIAM R. SOLLARS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State 6-12-10 ST.PAUL'S CEMETERY WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL, SERVICE, P. A 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee -ores M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to pr as a consequence of): **Examiner** Sequentially list conditions, it my less ing climate into cause. Enter Underlying Examine Due to or a consequence of) the attending physician and ched for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) page 2 should be detached Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1- Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Descripting Projection: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Thomas 7:05 a M I. Scott, Sr. May 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cecil 125 Woodall Road Perryville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 222-18-8937 77 07-31-1932 Director Delaware Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the twelften Evaluates to rectified at 1 ☐ Yes 2 X No Director MD Cecil Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code e filed within 72 hours after death with tall Hygiene. 21903 USA 125 Woodall Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: ģ 3 ☐ Widowed 4 🂢 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residential Security Security Guard 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Virgil Scott Glennie N. Downes ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 125 Woodall Road, Perryville, MD 21903 Pam Boyle/Daughter permit. Pages 1 and Decartment of Healt Important: If item 27 any injury or other 1 20c. Location - City or Town, State Pages 1 ; ment of H 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans 06-02-2010 Leola, PA Cremation Service 21. Signature of Funeral Service License 22. Name and Address of Facility Galena Funeral Home MOO 118 W. Cross Street, Galena, MD 21635 23a. Part . Ent if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediate Couse (Final disease is condition as COPO) Approximate Interval Between Onset and Death Physician veans disease ondition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed the burial-trans attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a d be detached for ∐Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 res 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' After this certificate 1 ☐ Yes 2. No 1 ☐ Yes 2.2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 TResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after dea... \*\*I Director: Aftr 1.X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD. D 0035779

State Registrar 31. Date file

2515. Bohemia Ave, Levilton, MD 21913-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bruce Obenshain

State of Maryland / Department of Health and Mental Hygiene U | U 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1:37am MINNIUA LEE TILLER 201C Tune /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata ivista a ical 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 20X Months Days Hours TENNESSEE Director 415-38-3314 90 FEB.22,1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28a-f show must be notified at 1XXes 2 □ No Director MD CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 23a 10200 LA PLATA ROAD 20646 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: þ 3 ★Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Minniva STORE CLERK AOUALAND CAMPGROUND 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EARNEST PHILLIPS (UNAVAILABLE) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 8190 PORT TOBACCO RD., PORT TOBACCO, MD20677 KIMBERLY SINES/GUARDIAN 20c. Location - City or Town, State JUNF Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If its any Injury or o 1 ☐ Burial 2 ☑ Kremation 3 ☐ Removal from State METRO.CREMATORY 11,2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, it is immediated as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No
9 □ Unknown 1 Live birth 2 Fetal deat
4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed oldago 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed spital or Attending Physiclan: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, pag 1 □Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Year) 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 6 Postofficed, Walday, MD, 20603 and address of person who completed cause of death (Item 23a) (Type, Print) Suite 101 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ Karen Mae Thodos 2010 ΑM 0447 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral**  $AUG^{(Month, Day, Year)}$  1960 1 □ M 2 🎇 F Hours Virginia Director 222-54-9228 49 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏋 No Maryland Ceci1 North East 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21901 420 Champlain Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Manuel Franklin Thodos Gertrude Mae Cox Boulanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Anderson/Daughter 420 Champlain Road, North East, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 8 1 D Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) 2010 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to ( as a conseq of): arrest Physician/ disease or condition Medical resulting in death) Examiner **BOXIO** Sequentially list conditions, Examine if any heading to immedia cause. Enter Underlying W19epec burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown þ Month Year Day Preonant at time of death the detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, best 2 No 3 Probably 4 Unknown 1 X Yes Completed has been Pholestero 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral ( 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 9c. License number completed cause of death (Item 23a) (Type, Print) Name and address of persor okanypan 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G907 9/23/10 JH

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Blanche Colbert Taylor 10:10 P M 2010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 4c. County of Death **Examiner** Fairfield Nursing and Rehab Center Crownsville Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🔀 F 89 Months Days Hours Min. Director Maryland Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland notified at Director Maryland Annapolis Anne Arundel 1 Yes 2xXNo 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò "natural", or items 23a o 21401 Funeral 866 Rudder Way U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2XXMarried by Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2XXNo Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed and Mental Hygiene.
is marked other than "natural aumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ella Small t of new. It If item 27 is mar nowhere traumatic en ပ Edward Leon Colbert Page 1 and 2 should be nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald S. Taylor/husband 866 Rudder Way Annapolis, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. st. 5/25/2010 Annapolis, Maryland Anne's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Sign 1 neral Service Lices Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ Anemia disease or condition resulting in death) days Medical Examiner Due to (or as a consequence of): year Dementia Sequentially list conditions. ē if any, leading to immediate

Enter Industrying

Cause (Disease or iinjury Due to (or as a consequence of): Examir Cardiomyopathy The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No jo Month Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4XXUnknown been si Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy performed? Yes 2XXNo certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA XX Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 XX Natural injury 5  $\square$  Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the units, date and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53111 May 24, 2010 30. Name and addre of person mpleted cause of death (Item 23a) (Type, Print) Hung T. Davis 2007 Tidewater Colony Annapolis, Maryland 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MAY 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY Physician/ 234 TANYA UMSTEAD 2010 1:15 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 1116 BOOKER DRIVE CAPITOL HEIGHTS 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours NOV 16 2 34 1954 WASHINGTON, DC 55 579-76-7888 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director MD PRINCE GEORGE'S CAPITOL HEIGHTS 1X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20743 Funeral USA 1116 BOOKER DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) NONE Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ISAIAH TAYLOR ALBERTA MCKEAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4631 MINNESOTA AVE., NE., WASHINGTON, DC 20019 LASHAWN TAYLOR/ DAUGHTER 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 06-02-2010 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Arterioscherotic Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 Dinknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examine 7 Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20

State Registrar 3001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

JUN 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Michele Allison Vance  $\mathbf{P}^{\mathsf{M}}$ 2010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Dove House 8. Date of Birth 5. Social Security Numbe If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 □ M 2 🔀 F Months Days (Month, Day, Year) Jan 31, 1959 Hours Mary Land Director 212-80-5212 51 Jan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 V No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 21158 United States 718 Young Way or items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 2 Radiology Technician Radiology injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic e Gwendolyn Arnold Muriel Leonard Vance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchell A. Vance/brother 10787 Folkestone Way Woodstock, Maryland 21163 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 6/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Si ure of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between onset and Depth Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t page 2 s To the Hospital or Attending Physician: The law autopsy performed' 2 1 certificate 1 Yes 2 1 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 [LNc 4 Nursing Home 5 Residence 6 X Other (Specify) HO5 PICE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Destitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 State Registrar

DHMH 17 Rev 7/2009

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar			land / De		t of H	ealth a		ental Hy		0 i 0	8702	
		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	Day	Year	3. Time of Death	
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Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of		4c. County of Death				
					ab Center	/ If I Indoor	Lona  If Under 1 Year   If Under 24 Hrs.				<u> </u>		Allegany	
Funeral		5. Social Security Number 6. Security Number 113-22-3734	M 2KF	7. Age (I	n yrs. last birthe	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Yea <i>r)</i> ch 21, 19	Col	Maryland	
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ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If them 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at	-	19a. Informant's Name/Relationship (7	ype. Print)		19b. N	failing Address	S (Street a	ınd Numb	er or Rura	al Route Numb	er, City or	Town, State, Z	(ip Code)	
and 2		Robert V	inci - Son						aft Ro	ad, Frostb				
Jes 1 Fof Hi or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	State	20b. Place of E cemetery,				С	May 11,		ation - City or		
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permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau		21. Signature of Funeral Service Licen	see			22. Name ar							Funeral Home P.A	
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Dhooisis		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.									Interval Between Onset and Death	
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ath. rr: Aft	atio	1 Natural 5 ☐ Pending investigation		illii, Day, I	ear) III	M		Yes 2	]No					
r Atterderector	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	20e. Plac	e of Injury ding, etc. (	- At home, farr (Specify)	n, street, factor	y, office			28f. Location City or To	Street and wn, State)	Number or R	ural Route Number,	
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Hosp 24 hol Fune stely fi	Medical	29a. Certifier  (Check only one)	niner: On the	ne best of the basis of each of the basis of each of the basis of each of the basis	xamination and	or investigation	n, in my o	ne, date a pinion, de	ath occur	red at the time	, date and	place, and du	e to the cause(s)	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier			-	29	c. License	e number			29d. Date	e signed (Mon	'h, Day, Year)	
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Registr	al	MAITY	L. Kar	SHALL !	p. 19	-								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5, 2010 Dolores Mae Vavrina /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico salisbury Rehabilitation & Mursing Ctr. a Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days 1 □ M 2X F 9/18/1930 Director 217-26-3029 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County event, the Medical Examiner: ust be notified at 1 ☐ Yes 2 ☐ No Director 28a-f MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō items 23a 74 Sandyhook Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Dolores Vay ning Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify Completed by Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Samuel Hiss Lillian Huber ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a.
Important: If Item 27 is
any injury or other trau Gail S. Hanle / daughter 74 Sandyhook Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signalura of Funeral Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) **Physician** 001-100 277 /Medical Due to ar as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due t (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No ed by the detached 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 sl autopsy performed? 1 □Yes 2 □ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 JMo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. le Funeral Director: Aff bletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

8 C3

State Registrar Ave-

200 C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rygistrar's Signature

Robins

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State		artment of Health and N		_		
	_	State Registrar	, ,	tificate of Death	, ,	. No.2 0 1 0	18704	
Physician Medica			achter		2. Date of Death Month May	Day Year 22 2010	3. Time of Death 2:45 AM	
Examine	er	4a. Facility Name (if not institution, give street and r Regency Park Assisted		4b. City, Town, or Location of Death  Gambrills		4c. County of Death		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth			
Director		579-38-0849 1 □ M 2 X Usual Residence of Decedent	F 80 Yrs.	Months Days Hours Min.	Month, Day, Ye Dec. 12,	1929 Co	Virginia	
-f sho	cto	10a. State 10b. County  MD Prince George	10c. City, Town or Lo	cation			10d. Inside City Limits  1  Yes 2 No	
or 28a	Funeral Director	MD Prince George	e's Bowie	10f. Zip Code	100	g. Citizen of What Co		
with t	era	16230 Cambridge Court		20715		United St	-	
items ler m	ᆵ	11. Marital Status 12. Was D		Was Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto		14. Race - Ame	rican Indian,	
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72 hou	Completed	15. Decedent's Education (Specify only highest grade complete	red)   (Give	dent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business	Industry	
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filed val Hyg		17. Father's Name (First, Middle, Last)			e (First, Middle, Mai	den Surname)		
Ild be narke	잍	Howard Frank Tinnell		Gracie				
nd 2 shou saith and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) David W. Wachter		ng Address (Street and Number or Rura Mayfair Place, Cr			Code)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State 20b. Place of Dispo cemetery, cren Resurrect	natory or other place)	Date 20	oc. Location - City or Clinton,		
permit. I Departn Importa any inju		21. Signature of Funeral Service Licenser	22	. Name and Address of Facility Bea	ıll Funera	al Home	Tally Idilot	
40 = 40	$\dashv$	23a. Part 1. Enter the disease, or complications th		512 NW Crain Hwy		MD 20715	Approximate	
Physician/ Medical		shock, or heart failure. List only one cause or immediate Cause (Final disease or condition a.	Failure to	Thrive	s respiratory arrest,		Interval Between	
Examiner		Due Due	to for as a consequence of):	Dementin	em s	teine	BUR.	
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	to (or as a consequence of):	, Dardinet	, crus	Cif	94131	
	cal Exa	that initiated events c	to (or as a consequence of):					
physics the b	을   	d						
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		in the past 12 morths?	outcome of pregnancy ive Birth 2  Fetal death 3  regnant at time of death 5  nknown	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year	
igned by	Dy Pu	Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobad	cco use contribute to	the cause of death?	
been should	etec	7171011100			24a. Was an		copsy findings available	
The law cate has page 2:	Som Comp				autopsy performe	prior to death?	completion of cause of	
certifi	ן מֿ	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  Hospital:		26. Place of Death (Checi			Assisted	
ing Phys	ate: 10	27. Mann Death 28a. Da	Inpatient 2 ER/Outpatier  ate of injury  Jonth, Day, Year)  28b. Time of injury	28c. Injury at work?	ome 5 Residence 28d. Describe how	e 6 🗹 Other (Specinjury occurred	ty) Living	
death death y the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm, stre	M 1 Yes 2 No	28f Location (Stron	et and Number or Rui	ral Route Number	
urs after ral Directled in by		4 - Horricide determined bu	ilding, etc. (Specify)		City or Town, S	State)		
the Hosp hin 24 ho the Fune npleted fi	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination and/or invest	occured at the time, date and place, ar igation, in my opinion, death occurred at leath occurred at the time, date and place	t the time, date and p	place, and due to the o	ause(s) and manner stated.	
No Nith		29b. Signature and title of certifier	the	29c. License number 05a139	29d	Date signed (Month)	Day, Year)	
		30. Name and address of person who completed c	ause of death (Item 23a) (Type, P	mill Bluck. So	420	Gamballs	MD 21057	
State Registrar		31. Date filed (Month Pay 2 6 2010 32	. Registrar's Signature	har		/	<u></u>	

		END#1 per PHY	State of Ma O HEALTH DEPT.	ryland / D	epartment of Certificate of	Health and	Mental Hy		0   0	18705
Physician /Medical Examiner	4a. Facility N		give street and number) Jursing Home	dray Ja	an Audrey Wyv  4b. City, Town, Clinto	or Location of Deatl	2. Date of De Month May	22 4c. 0	Year 2010 County of Death	
Funeral Director	5. Social Sec 218-24			(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.		th ly, Year)	9. Birth	place (State or Foreign Intry)
h the Maryland or 28a-f show or collined at	MD 10e. Street a		e George's	10c. City, Town o	or Location arlboro 10f. Zip Code			10g. Citiz	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2X No untry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be routilled at TO Re Completed by Finneral Director	11. Marital S	croom Stat	12. Was Decedent Ev Armed Forces?		20772  13. Was Decedent of If Yes, specify Cut  1  Yes		Specify Yes or No to Rican, etc.)	1-	ed Stat 4. Race - Amer Black, White Specify: Whi	ican Indian, , etc.
ad within 72 hour ygiene. For than "natural to the Marie II."	Elementar	15. Decedent's (Specify only highest y/Secondary (0-12)			Decedent's Usual Occu Give kind of work done life. DO NOT use retire me Maker	during most of wor	rking	16b. Kin	ndustry	
should ind Mer marke umatic	George	Name (First, Middle, La Sweeney ant's Name/Relationshi		195. [	Mary F	18. Mother's Name (First, Middle, Maiden Surname)  Mary Rebecca Moran  and Number or Rural Route Number, City or Town, State, Zip Code)				
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tran	Cynthia Wyvill duCellier/niece 7207 Croom Station Rd., Upper Marlboro,    20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or cemetery, crematory or other place)   20c. Location - City or cemetery, crematory or other place)   Fort Lincoln Cemetery 05/25/2010   Brentwood,									own, State
permit. Pages Department of Important: If it any injury or o	21. Signatur	e of Funeral Service Li			22. Name and Addr	ess of Facility Be n Hwy., E	eall Fund Bowie, M	eral D 207	Home	Approximate
Physician /Medical Examiner	shock,	or heart failure. List of Cause (Final condition	aa.	consequence of	1		o or respiratory a			Interval Between Onset and Death
	d									
nat the death certificand by the attending phetached for use as the physician/Med	in the p	cedent pregnant last 12 months? s 2 SNo known	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3  Ectopic pregnan 5 Other (specify)	су		23	3d. Date of deli Month	very Day Year
requires that the de een signed by the a rould be detached f	Part II. Other	r significant condition	s contributing to death but	t not resulting in t	he underlying cause gi	ven in Part I.	23e. Did t			the cause of death?
24a. W au per diversity of the part of Death 28a Date of Injury 28b Time of 28c Injury at 28d Decorit								psy rmed? 2 <b>124</b> No	prior to death?	topsy findings available completion of cause of
ine ine	examine 1 Yes  27. Manner of Natu 2 Acci 3 Suic	2 No of Death iral 5 Pending dent investiga ide 6 Could no	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon 28a. Date of Injury (Month, Day, Year)  Pending investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Work?  M 1 Yes 2 No					how injury	occurred	
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Certifical Medical Certifical	4 ☐ Hom	r 1⊟ Certifying	Physician: To the best of caminer: On the basis of	(Specify)  f my knowledge, examination and	n, street, factory, office death occurred at the for investigation, in my	time, date and place opinion, death occ	e, and due to the	wn, State)	and manner as	ral Route Number, stated. to the cause(s)
To the Hosp within 24 hou To the Fune completely fi	<b>&gt;</b> C	re and till of certifier	and manner state	ed.						
State Registrar	$\omega$		ANNER MO  32. Registrar	ath (Item 23a) (T	29c. Licen 377  ype, Print)  LVI 1554m  Sauld	Rod. For	I WAS	Ningt	m, mm	yland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23 Physician/ Grover Eugene Welborn, Jr. 2010 6:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Care & Rehabilitation Ctr Crofton Anne Arundel 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1/24/1921 Connecticut Director 041-18-5087 89 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 🎇 Yes 2 🗌 No Prince George's Maryland Bowie 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 2419 Kinderbrook Lane 20715 items should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1-2-Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 0. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates, 1940-46 Specify 3 X Widowed 4 □ Divorced Specify: "natural", White the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Tour Guide Tourism years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည May Golden Grover Eugene Welborn, Sr. and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; If item 27 is any injury or other trau Jack G. Welborn/ Son 3354 Oak Drive, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 6/1/10 Crownsville, MD 21. Signatur June 1 22. Name and Address of Facility George P. Kalas Funeral Home icense 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition <u> 1000</u> Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit ementio Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) To the Hospital or Attending PhysIclan: The law requires that the death of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for completed filled in by the funeral director, page 2 should be detached for completed filled in by the funeral director, page 2 should be detached for completed filled in by the funeral director, page 3 should be detached for completed filled in by the funeral director, page 3 should be detached for completed filled in by the funeral director, page 3 should be detached for completed filled in by the funeral director. in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 🗌 Yes 2 🗆 No 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Midical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane, Bowie, MD 20715

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **MAY 2 6 2010** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Day</sup> 2010 Year Warren Virgie Lee 18:55P M May 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Months Days Min 05/05/ 579-50-7779 South Director 78 Carolina Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Capitol Heights Yes 2 No MD PG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6563 Ronald Road 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ь <u>2</u> 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: If Yes, Give Specify: Black "natural", 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. larked other than College (1-4 or 5+)
2 years Elementary/Seconday (0-12) Chef Private Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental H
Important: If item 27 is marked ott
any Injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Annie Benn Leonard Dickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20743 6563 Ronald Road; Capitol Hgts, Gloria Carey/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State Lincoln Mem. Cem. 06/01/10 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 4594 Beech Road, 20748 Freeman Funeral Svc; Temple Hills, MD 23a. Part 1 Enter the disease, or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Director for as it nonsequence of If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \( \text{Specify} \) 1 Yes 1 A Inpatient 2 ER/Outpatient 3 DOA ဂ္ 24 hours after death.

Funeral Director: After this leted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🐣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 600 16 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 7600 Carroll Ave; Takoma Park, 20912 David Jacobs MD31. Date filed (Month, Day, Year) 32. Registrar's State JUN 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ JOSEPHINE WILSON 6:38 PM MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGES Examiner HYATTSVILLE 7715 BENDER RD. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days Hours Min. April 16,1921 1 □ M 2 🗓 F MARYLAND 89 Yrs Director 579-16-0248 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director be notified 1 🛱 Yes 2 🗆 No MD PRINCE GEORGE'S 28a-f HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a USA must k 20785 7715 BENDER ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married ò 1 ☐ Yes If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the HOUSEWIFE PRIVATE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ LILLIE TOLSON JUNIOUS ALBERT WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health MAXINE WILSON/ DAUGHTER 7715 BENDER ROAD, HYATTSVILLE, MARYLAND 20785 tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important; If it
any injury or o ŏ 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/7/2010 CHELTENHAM, MARYLAND VETERANS CEMETERY 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE 6 MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter charrying Cause (Disease or iinjury Examiner Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death a I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? **GANGRENE** autopsy performed' 2 🗓 1 ☐ Yes 2 ☐ No HYPERTENSION Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Director; / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital within 24 hours a

To the Funeral C

completed filled within 2 To the F

State

DR. WILLIAM DUBOYCE 12158 CENTRAL AVE., MITCHELLVILLE, MD. 20721 JUN 0 2 2010

no completed cause of death (Item 23a) (Type, Print)

29a. Certifier

only one)

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NINSTA Month\_ OHO AM عادة المحر Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3675 Solomons Island Rd. Anne Arundel Harwood 6. Sex If Under 1 Year If Under 24 Hrs Hours Min. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral April Day 4 - 1949 578-64-8911 1 🖾 M 2 🗆 F Months Days Washington, DC 61 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ₹ Yes 2 🗆 No MD Prince Georges Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20774 22 Herrington Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 4 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 Divorced 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event \*\*\*. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Postal Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Richard Winston Marie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Winston/ Wife 22 Herrington Dr., Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State MD. Veterans Cemetery 06/08/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 rain Physician/ was disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a sonsequence of n attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 ☐ Probably 4 ☐ Unknown plnods . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 1 Yes 2 **X**No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) No Spice 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural iniury 5 Pending nours after death.

neral Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours at To the Funeral D completed filled it Medical 29a. Certifier 1. Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Gregory Lawrence Williams 20, 2010 May 6:55 P. 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death Kensington Nursing & Rehabilitation Kensington Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. 579-66-7060 60 July 21,1949 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 McComas Avenue 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lawrence Williams Mossie Marguerite Rhone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20011 19a. Informant's Name/Relationship (Type. Print) Terry Elizabeth Muse (Sister) 430 Missouri Avenue, N.W.; Apt.B-1; Washington, DC 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, andalph Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IMMUNDOFFICIENCY GUIRED disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury pue lo lor as a conseduence ofi that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24PNo 1 ☐ Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner the death certificate be executed

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After thi funeral of

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Medical Examinar must be notified at

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is marked other than

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once.

Baltimore, Maryland 21215-0036

Box 68760,

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Records,

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Division

or Attending Physician:

death.

Examiner burial-tran Physician/Medical the attending p as use signed by the þ Completed page 2 s Be

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a, Certifier

4 Homicide

(Check only one)

5 ☐ Residence 6 ☐ Other (Specify)

Other: 4 Nursing Home 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier sw, mo 29c. License number 00057124 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Truong Bao, M.D.; 10110 Molecular Drive; Suite 206; Rockville, Maryland 20850

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State Registrar 31. Date filed (Month, Day, Year) JUN 0 2 2010

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

			Pleas	e Type or Prin Amend I State of Ma	tin Black L	gdelible/le	y Fostice	<b>All Capi</b> e Mental Hy	es Are Le	egible.	
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	ind show at	្រ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10	0d. Inside City Limits
	Maryla 28a-f s etified	Director	DE Susse	×	Bridgev	ille					1 🗌 Yes 2 🗐 No
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21;	d within 72 ygiene. her than ' ht, the Me	Be Co		1		eptioni	st		Bowma	n & S	ons
and	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last				18. Mother's Na			ime)	
Maryland 21215-0036	2 should be file th and Mental I 27 Is marked o traumatic eve	1	William Satch		19b. Maili	ng Address (Street	Marion t and Number or Ru			, State, Zip C	ode)
Σ,	C = 21 +		Calvin Warner	/Ex-Husbar			, Onley				
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Baltimore,	permit. Page 1 and Department of Heal Important; If item 2 any Injury or other once.		4 Donation 5 Other (Special Signature of Funeral Service Lice		Direct (	Cremato	ry, 6/2	2/2010	Dover	DE	
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Box 68760	eath certificate be attending physicie d for use as the bur	Physician/Medica	IF FEMALE:		1975						
9 XC	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnar Other (specify)	ісу		- 1	Date of deliver	ry Day Year
Ö.	the dea	hysid	1  Yes 2  No 9  Unknown	9 Unknown	ille of death 5 L	_ Other (specify) _					
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<u>=</u>	Physician: The law this certificate has al director, page 2 s		25. Was case referred to medical	Ι		26. F	Place of Death (Che	1 🗆 Yes	2 🗗 No	1 🗌 Yes 🔞	2 □ No
Zi:	hysici his cer il direc	၉	examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpatier	Ott	ner:	lome 5 🗆 Resi	dence 6 🗆 O	ther (Specify)	
n of	ding P h. After t funera	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Inju wor	k?	28d. Describe I	how injury occi	urred	
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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  within 24 hours after death.  To the Laneral Director, After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 ☐ Medical Exar	ysician: To the best of m nîner: On the basis of exa	mination and/or invest	igation, in my opini	ion, death occurred	at the time, date a	and place, and o	due to the caus	se(s) and manner stated.
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	45U 1		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, F	-1-4			_		
	) Stat	e	An thon Frey 31. Date filed (Month/Day, Year) JUN 0 1	M - D . 101	Signature &	oll St.	Salist	oury,	mP-c	2180	1
	Registra	-	JUN 0 1	2010 Seneu	a B. A	ave					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year 6:40 am **Physician** Wolfe rances Suzan 11 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett Center Oakland Nursing & Rehab. Oakland If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 🎛 F 59 Oct.30,1950 Florida Director 267-90-8207 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Michael Evanciant must be nothered at 1 □Yes 2¥ No Director Garrett Oakland MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 2732 Cranesville Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Law Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Geraldine White Bobby Lee Adkins မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Wolfe/ Husband 2732 CranesvilleRD., Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o 1 
Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 5/14/10 Oakland, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 203 S. Second St., Oakland, MD 21550 in a that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only or Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year P.O. 1 □Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 **N**0 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 00061801

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 4 2010

Kenneth Buczynski 311 N. 4th St., Suite 1, Oakland, MD 21550

30. Name and address of person who is impleted cases of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 7, 2010 Physician/ ALICE MARIE WOOD 11:50AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8385 BILLINGSLEY ROAD WHITE PLAINS CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 😿 F Months Days Hours Min. MD Country) 214-42-5502 66 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State **Funeral Director** MD. CHARLES WHITE PLAINS 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 8385 BILLINGSLEY ROAD U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify:WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) QUALITY AUTO Elementary/Seconday (0-12) College (1-4 or 5+) OWNER/BOOKKEEPER CLEANING CO. 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE WILSON HAMILTON, SR. ALICE MARIE QUADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH G. WOOD, SR.-SPOUSE 8385 BILLINGSLEY RD. WHITE PLAINS, MD. 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 6-9-10 ALEX., VA. Signature of Juneral Service Licenses M0047 RAYMOND FUNERAL SERV LA PLATA, MARYLAND 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MO Medical Due to (or as a consequence of): Examiner Examiner Completed by Physician/Medical Be

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, n 24 hours after death.

le Funeral Director: Af
pleted filled in by the fu within 24 hou To the Fune completed fi

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Certificate:

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):								
	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  9 ☐ Unknown	23d. Date of delivery  Month Day Year							
Part II. Other significant conditions of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Yes 2 ☐ No							
25. Was case referred to medical	26. Place of Death (Che	eck only one)							
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing I	Home 5 K Residence 6 □ Other (Specify)							
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred							
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Exami	cician: To the best of my knowledge, death occured at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place death occurred at the time, date and place the property to the best of my knowledge death occurred at the time, date and place the property to the best of my knowledge death occurred at the time.	at the time, date and place, and due to the cause(s) and manner stated.							

29c. License number 00001923 29d. Date signed (Month, Day, Year)

State

egistrar's Signature

LBULA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death Town, or Location of Death Examiner Ker Rup ente If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
MAY 2, 1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Numbe **Funeral** Min. Months Days Hours 1 M 2 X F 86 059-20-9206 **NEW YORK** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a State 10b. County 1X Yes 2 □ No Directo MARYLAND QUEEN ANNE'S CENTREVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or the Medical Examiner must be r 639 HARMONY WAY 21617 UNITED STATES Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygione. and It Item 27 is marked other than "natural", or item It Item 27 is marked other than "natural", or other traumatic event, the Modical Examinary or other traumatic event, the Modical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify WHITE Completed by Specify: 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL PHARMACY CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HENRY WHITE WINIFRED HART ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVIN CAICO/SON 639 HARMONY WAY, CENTREVILLE, MD 21617 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE' CREMATION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2010 21. Signature of Funeral Service Licensee FETALOWS Add HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or es a consequence of): Examiner Dheumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed STa attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Alcohoh IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown stinal Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl 24a. Was an autopsy hypoal bumine mia 2 **X**No 1 Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case eferred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Iniury 5 Pending ours after death. neral Director: Af filled in by the fur 1 □Yes 2 □ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chastestown MD21620 100, Brown Street, 37 Registrar's Signature

1)0069457

Samantha

Death

Year

2 No

29d Date signed (Month, Day, Year)

June 3, 2010

To the Hospital or Attending Physician: The law requires that the death certificate be  $\# | \lozenge \circlearrowleft \lor \lozenge$  Division of Vital Records, P.O. Box 68760 within 24 hours after death Fo the Funeral Director:

> 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

du

and manner stated

State Registrar

Medical

29b. Signature and title of certifie

arot

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

OCME

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathtt{Ju}^{\mathtt{Month}}_{\mathbf{ne}}10$  , 2010 ar 8:50 A John Jeffrey Allen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Montgomery Hospice Casey House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🛛 M 2 🗆 F Months Days Hours Min Pennsylvania Director 63 June 1947 211-38-8689 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Tyes 2X No Silver Spring Maryland Montgomery 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 20910 United States 10013 Stoneybrook Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates.Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ John Rex Allen Mary Louise Frost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 10013 Stoneybrook Drive, Silver Spring, Maryland 20910 Melissa Colbert / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) cemetery, crematory or other place) Montgomery Crematorium, Inc. June 13, 2010 Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 4/ M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Between Immediate Cause (Final Onset and Death Physician/ Pancreatic Cancer disease or condition յ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy death? 2 **X** No 2 🗆 No 1 Tes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6X Other (Specify) Hospice 1 Yes 2X No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral in 24 hours atter use.... he Funeral Director: After the maleted filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) ë 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Certificat 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) CRA June 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar CRNP

32. Registrar's Signature

Diane Ruckert,
31. Date filed (Month, Day, Year)

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Maria Bernal Month Physician/ 5:27 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 60 Bensmill Court Reisterstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day,
June 2 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Country) Colombia 1 🗆 M 2 💢 F 148-90-7207 **Director** 89 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits 10a, State with the Maryland Director 1 Yes 2XXNo Reisterstown Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21136 USA 60 Bensmill Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others." Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Completed by White 1 XYes 2 □ No Specify: Colombian Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Concepcion Ramirez Vicente Sarmienti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Bensmill Court Reisterstown, MD 21136 Liz Burridge/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Greenmount Cemetery 6/15/10 Baltimore, MD 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD21215 grou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final <sup>b</sup>nysician/ cancer SKIN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has certificate Yes 20 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. ieral Director A Investigation ☐ Accident 3 
Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rygapakse, M.D. 28355milh Av - 5-235, Bullimore, MD. 21209. N.S. Rayapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

			Please	State of M								Jibie.	
		1	For State Registrar	Otato or W	ai yiai i	•		of Dea			eg. No.2	10	18718
			Decedent's Name (First, Middle, Last	)				<u> </u>		2. Date of Death	1	Year	3. Time of Death
Р	hysiciai Medic	al .	Tean Beisel							06-06-2			12:25 A™
	Examine		4a. Facility Name (if not institution, give				4b. City, 1		ation of Death	. 0	4c. County of Death		
			Madana 17cm, 5. Social Security Number 6. Se		e (In vrs. la	st birthday)	If Under		Inder 24 Hrs.	8. Date of Birth	17 %	9. Birthplace (State or Foreign	
	uneral irector		154-14-0158	☐ M 2 💢 F	88	Yrs.	Months		ours Min.	11 <sup>M</sup> 29-1y	21 21	Coun	
P	how at	. 1	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
laryla	3a-f s iffied	ecto	MD Harford		На	rve d	e Grad	ce					1 ☐ Yes 2 🗶 No
the M	or 28	₫	10e. Street and Number				10f. Zip			1	0g. Citizen of	What Cour	ntry?
with	nust b	Funeral Director	35 Telestar Way					21078			USA		
death	r item ner n		11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decede If Yes, speci	ent of Hispar fy Cuban, M	ic Origin? (Spe exican, Puerto l	cify Yes or No- Rican, etc.)		ce - Americ	
)36 after	al", o	d b	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No		1 🗌 Yes 🛭	No Sp	ecify:		Specif	y: W	nite
5-0 hours	natur dical I	Completed by	15. Decedent's Ed (Specify only highest gra	lucation	- )	16a. Dece	dent's Usua	Occupation	most of worki	ng I	16b. Kind of E	Business In	dustry
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A with	int, th	0)	12 17. Father's Name (First, Middle, Last)			Secr	etary	18	Mother's Name	e (First, Middle, M			Tetta
land be file	kedo	횬	John Chmielewski					- 1		Chmielev		,0,	
Maryland 21215-0036 12 should be filed within 72 hours after	s mar		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Maili	ng Address	(Street and I	lumber or Rura	l Route Number,	City or Town,	State, Zip (	Code)
<b>X</b>	m 27 i		Gerald Nelson (So	n)		35 T	elest	ar Way	Harve	de Grace	e, MD 2	21078	
Baltimore, permit. Page 1 and	Department or result when the way to see that "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		lace of Dispe emetery, cre	matory or of	her place)	- 1		20c. Location		
Itim it. Pag	rtant		4 ☐ Donation 5 ☑ Other (Specify  21. Signature of Funeral Service Licens		ı#H1g					-2010 F			
Ba	Impor any in		21. Signature of Funeral Service Licens	90						Rd Bel			e of BelAir 14
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	sician/		Immediate Cause (Final disease or condition	-	nuc								Onset and Death
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68760 Dertificate	ding p	/We	IF FEMALE:	23c. If yes, outcome	of pregna	ncy					224 0	ate of deliv	eni
Box (	attending physi I for use as the b	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a	2 🗆 Feta	ldeath 3	☐ Ectopic p ☐ Other (sp					lonth	Day Year
D. B	by the	hys	9 Unknown	9 Unknown									
P.O.	gned be det	by F	Part II. Other significant conditions of	_	but not res	ulting in the	underlying o	ause given ir	n Part I.	HIP.			he cause of death?
rds equire	nould	eted	PEARL PROTSING										psy findings available
e law r	has b	Completed by Physician/Medi	1512 deficient							24a. Was ar autops perforr	y ned?	prior to co death?	mpletion of cause of
<u>د</u> ::	ifficate or, pa	Be Co	25. Was case referred to medical	· -			_	26. Place	of Death (Check	1 🗆 Yes :	2 46	1 Pes	2 LJ No
Vita Iysicia	is cer direct	To B	examiner? 1  Yes 2  No	Hospital: 1 🗌 Inpat	ient 2 🗌	ER/Outpatie	ent 3 🗆 DO	Other: 4	☐ Nursing Ho	me 5 Reside	nce 6 🛂 Ót	her <i>(Specif</i> )	Assistan Live
of Ing Pt	fter th		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of inju	ury ay, Year)	28b. Time of injury	-	8c. Injury at work?		28d. Describe ho	w injury occu	rred	
Sion ttend	tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		iurv - At ho	me. farm. st	M reet, factory		2 🗆 No	28f. Location (St.	reet and Num	ber or Rura	I Route Number.
Division of Vital Records, tal or Attending Physician: The law requires after chart.	l Direction by	Cer	4 Homicide determined	building, et	c. (Specify	)	,,	,		City or Town			· · · · · · · · · · · · · · · · · · ·
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thin 2.	the F	Me	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practioner: To the	e best of m	y knowledge,	death occur	red at the tim	e, date and plac	e, and due to the	cause(s) and r 9d. Date sign	nanner as s	tated.
<b>P</b> . ≥	\$ <b>₽</b> 8		► Wands K/	h m	,			D 3129		1	/0//	0	
			30. Name and address of person who o	ompleted cause of	death (Item		Print)				7 0,		
	Q		Wendy Kloss		701		scool 1	eve i	Bant	no	21206		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regist			6-	4.1					
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State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	Decedent's Name (First, Middle, Last)					Day Year	3. Time of Death 2336 hrs
Medical Exami	ner	DORIA MARIA BETHEA  4a. Facility Name (if not institution, give street and number)	4	h City Town or I	Location of Death	June 8, 201	10 4c. County of D	
		Civista Medical Center		LaPlata	ESSOCION SI ESSOCIA		Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Year		8. Date of Birth		. Birthplace (State or oreign
Director		087-58-9123 1_M 2\(\text{X}F\) 42	Yrs.	Months Days	Hours Min.	09/15/	1967	Country) NY
<b>≥</b> :		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location					10d. Inside City Limits
ow any								1 X Yes 2 No
Maryland 28a-f show d at once,	çi	DC Was	shingtor T	10f. Zip Code		10	g. Citizen of What (	Country?
the Ma	Director	2771 Langston Pl. SE		20020			USA	
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	era	11. Marital Status 12. Was Decedent Ever in U.		Decedent of His	panic Origin? ( Sp Mexican, Puerto			merican Indian, Black,
r death	Funeral	1 Yes 2 X No				rcan, etc.)		
hours afte 'natural", Examiner	ক্র	Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade completed)	*intelliged	Yes 2X No	specify: on (Give kind of w	ork done	Specify: B	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			DO NOT use retir		, ob. Tana di Badin	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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5-00 illed wit Hygien d other		17. Father's Name (First, Middle, Last)	1,000	1	18.Mother's Name	(First, Middle, M	aiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	To Be	Richard Dawson  19a. Informant's Name/Relationship (Type, Print )	19h Mailing		Albertee		3. ber, City or Town, S	State Zin Code)
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her transmatic event, the Medical Examiner must be notified at once		Alberteen Jenkins - Mother		Langston		Washingt		20020
_ = = = = =	- 1	20a. Method of Disposition 20b. F		ion (Name of cem		Date	20c. Location - Cit	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		A Bullar 2 Cremation 3 Removal from State	•	emorial	Cem   6-1	6-2010	Landover	, MD.
Salti ermit. epartu nporta jury o	1	21. Signature of Funeral Service Licensee	) 22 Na Mai	me and Address	of Facility Funeral	HOme of	f Marylan	.d
	-1	23a, Part I. Enter the disease, or complications that caused the death.	430	08 Suitla	and Rd.	Suitlar	nd, MD 20	
Physician /Medical		failure. List only one cause on each line.		a mode or dying,	sudi i as cai diac oi	respiratory arre	st, shock, or near	Between Onset and Death
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687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	2 Feta	al death 3	Ectopic pregna	ncy	Month	Day Year
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O. B. at the de lby the tached f		Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause gi	iven in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?
ords, P.O. v requires that the sbeen signed by the should be detached.	ē ē					1 Yes	2 <b>✓</b> No 3	Probably 4 Unknown
ords	Sete					24a. Was a autops	sy prior	e autopsy findings available r to completion of cause of
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  Al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the co	ligat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street	, factory, office be	uilding, etc.			or Rural Route Number, City
Division pital or Attene ours after death eral Director: filled in by the	Certification:	4 Homicide determined (Specify) Interstate/E	Express			or Town, St Southbound R	ate) oute# 5 @ Oaks	Road, Charlotte Hall, Md.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transit		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledgene) 2 Medical Examiner: On the basis of examination at	ge, death occurr	ed at the time, da	te and place, and	due to the cause	e(s) and manner as	stated.
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination al and manner stated.  29b. Signature and title of certifier	nd/or investigation	29c. License		t the time, date a		(Month, Day, Year)
	~	250. Signature and little of certifier		O.C.N			June 10, 201	
	-	30. Name and address of person who continued cause of death (Item	23a)				-, -, -, -, -, -, -, -, -, -, -, -, -, -	
		Russell Alexander MD. Assistant Medical Exam		Penn Street,	Baltimore, MI	21201		
	ate		ire	,	<del></del>			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06-03-2010 10:20 AM Louis Herbert Brown Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 x M 2 □ F Months Days Hours Min. 08-07-1922 87 218-10-2234 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 951 B Redfield Rd 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 No 1 Yes 2 No Specify: If Yes, Give Specify:White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry 2 should be filed w...
with and Mental Hygiene.
wed other than "r." (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Public Relations Printing & Binding Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herbert Oliver Brown Margaret A. Plack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daretta A. Brown (Wife) 951 B Redfield Rd Bel Air, MD 21014 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4 Donation 5 Other (Specify) 06-09-2010 Owings Mills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician*i* disease or condition resulting in death) com Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leaving to inmediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform After this certificate 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1+03 PICQ 2 🗆 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending April 5, 2010 Lunknow 1 L 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number City or Tawn, State) 451 Red field Rd 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Ø no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Irim 31 Date filed (Mon State Registrar

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	Director		Usual Residence of Decedent	1 L M 2XXF 7	/	Yrs,			Aug. 4	193	32   Ry	ve. N.Y.	
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Maryland 21215-0036	d Mer d Mer mark matic	ľ	George Edward F  19a. Informant's Name/Relations						Rossell				
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imo	Page ment cant: It ant: It		1 XI Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Bei	Air N	natory or other place Memorial Gr	ďns. 6~:	16~2010	Bel	Air, N	1d.	
Baltimore,	purmit. Page 1 and 2 shu Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service L	Licensee		<b>E</b> <sup>2</sup>	Name and Addres	anfige pune	eral Home	9		0.7	
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ox 6	ath cea attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 🔲 Fetal	death 3	Ectopic pregnancy Other (specify)	У		23	3d. Date of d Month	elivery Day Year	.
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Division	or Att	Serti	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			ne, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or R	ural Route Number,	
	Hospital or Attending Physician: The law requires that the death certificate be \$4 burns after death. Funeral Director: After this certificate has been signed by the attending physici leted filled in by the funeral director, page 2 should be detached for use as the bu		29a, Certifier 1 Certifying	Physician: To the best of	mv knowled	dge, death o	ccured at the time.	date and place.	and due to the ca	use(s) and	manner as s	tated.	
	To the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by	Medical	(Check 2 Medical E	Examiner: On the basis of ex Nurse Practioner: To the l	kamination a	and/or investi	gation, in my opinior	n, death occurred	at the time, date a	nd place, a	and due to the	cause(s) and manne	r stated.
_	To the I within 2 To the I complete		29b. Signature and title of certifier	110		Mr	29c. License				_	th, Day, Year)	
			1 /hand	MU. X	me.	1/10	- D/	ナヴナク		June	15)	2010	
	15		30. Name and address of person with a nghall A.	who completed cause of de	eath (Item 2	23a) (Type, P	onth	Charles	s St.	Tows	on, M	aryland :	2120
	Stat		31. Date filed (Month, Day, Year)	32. Registra			9				J	/	
	Registra	ar	IIIN 1 6 2010	( William )	1. 4	auto							

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t

> 7501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

۵

Signature and title of certifier

9c. License number

DRIVE

29d. Date signed (Month). Dav. Year)

TOWSON.

2010

MARYLAND

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Day Physician/ JUNE 2010 MARGARET B. BURKE 11:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 - M 2 -XF Months Days Hours Min. (Month, Day, Year) MARYLAND Yrs. 80 Director 218-26-5930 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits **Funeral Director** 28a-f BALTIMORE 1 Yes 2 No MD NOTTINGHAM 5 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 7872 ROLLING VIEW AVENUE 21236 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married "natural", or Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than " College (1-4 or 5+) Elementary/Seconday (0-12) DIRECTOR OF DAY CARE CHURCH YEARS Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 NORMAN CHENOWETH MARGARET LIPPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 BARBARA BURKE/DAUGHTER 3116 CHESLEY AVE. BALTIMORE, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2010 PARKWOOD CEMETERY BALTIMORE. MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOO217 THE JOHNSON FUNERAL HOME, P.A. LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) acute myelogenous buteni Medical Due to (or as a cons quence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12/months? o Pregnant at time of death 5 Other (specify) Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dimonary alsego Were autopsy findings available 24a. Was an prior to completion of cause of death? has Yes 2 No 2 🗌 No certificate 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2×2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral completed filled in by the funeral completed filled Natural 5 Pending М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21204 555 lon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

		1	For State Registrar	State of	Marylar	•	artment of H Hificate of L		d Mental Hy	gien/ Reg. N	2010	187	124
			Decedent's Name (First, Middle	e, Last)					2. Date of De		10.	3. Time of	f Death
Physic Me	cian. dica		Annelise Ruth	Ball-Heine					June 11	, 20	010 Year	1:43	АМ
Exan			4a. Facility Name (if not institution	n, give street and numb	per)		4b. City, Town, or	r Location of D			c. County of Dea		
1			Shady Grove Ad					kville			Monte		
Funer Direct			5. Social Security Number 080–18–9534	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Bir Min. (Month, Da December	rth a <i>y, Year)</i> 18,	1923 G	rthplace (State o ountry) ermany	r Foreign
nd how	1	- 1	Usual Residence of Decedent  10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation					10d. Inside Ci	itv Limits
laryla 3a-f s iffied		5	Maryland Mo	ntgomery		Co	ithersbur	co				1 🗆 Yes	
the N or 24	2	<u> </u>	10e. Street and Number	megomery		- Ga	10f. Zip Code	- 5		10g. C	Citizen of What C	ountry?	
s 23a		<u> </u>	9701 Fields Ro	ad # 1101				20878		U1	nited St	ates	
death item	اً ا		11. Marital Status	12. Was Deced		S. 13.\	Was Decedent of H f Yes, specify Cuba	ispanic Origin? In. Mexican. Pi	(Specify Yes or No-	-	14. Race - Am		
after after xamii	1	2	1 Never Married 2 Mar 3 X Widowed 4 Divorced	If Yes, Give			☐ Yes 2 🗓 No				Black, Whi	•	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		Corribiered		Year or Date ont's Education	es.	16a Decer	dent's Usual Occup	ation		16h	Specify: Whi		_
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within giene	8		12	College (1-2	+ Or 3+)		Sales	Clerk		Dep	artment	Store	
nd filed tal Hy doth event	á		17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	, Maider	Surname)		
Yla Jild be Men narke		Н	Ernest Bach					Elis	abeth Bea	tri	ce Marx		
Mar Shou hand Tis n			19a. Informant's Name/Relations	hip (Type, Print)			-		Rural Route Numbe				
and and term 2		-	Jeff Ball/Son 20a. Method of Disposition		206		Caprice ( sition (Name of	Court,	Loveland,	1	io 45140 Location - City o		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		-	1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (		State (	cemetery, cren	natory or other plac	· i		1	,		
altir nit. P artme ortar injur	انه	1	21. Signatur of Funeral Service		lCre	tgomer matori	um. Inc.		ne 14, 2010				ıd
a Feer a	8		Haron 11	harton	МО	1530 30	bert A. Pun O West Moni	mphrey Fu	meral Home/ Avenue, Rock	Rock	ville, Ind e. Marvla	nd 20850	
		1	23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that ca	used the deat						//	Approximat	
Physician	V.		Immediate Cause (Final disease or condition		ythmia						2	Interval Bet Onset and I	
Medic Examine		1	resulting in death)		r as a conseq								
LXCIIIII	•	.	Sequentially list conditions,	b. Pneum									
ed sit	- i		if any, leading to immediate Cause (Disease or linjury		r as a conseq	,							
execute an and ial-tran	Fyaminar		that initiated events resulting in death) Last		Renal	Failu	re						
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\$760 ficate be g physicas the b	1	1		- u.				<del>-</del>					
certif	\ 2		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna	ancy	Ectopic pregnanc			- 1	23d. Date of de	elivery	
Box 68 death certifi he attending	Dhyeician/M	5	in the past 12 months?  1 Yes 2 XNo		ant at time of		Other (specify)	у,			Month	Day Y	Year
Records, P.O. Box 68760 V <sub>4</sub> The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi			9 Unknown  Part II. Other significant condition			sulting in the u	nderlying cause giv	on in Bort I	00- P:11				
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detach.	2	2	art ii. Other significant conditi	ons contributing to dea	atti but not res	suiting in the u	ndenying cause giv	en in Faiti.			use contribute to		
requir	Completed	5											
<b>/ital Reco</b> sician: The law i certificate has b iector, page 2 s	8	1							— 24a. Was auto		prior to death?	topsy findings a completion of c	ause of
in: The			25. Was case referred to medical				oe Di	and of Dooth //	1 Tes	2 <b>X</b> N		s 2 No	_
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of of g Phy g Phy erral c			27. Manner of Death	28a. Date of		28b. Time of injury	28c. Injury	/at	28d. Describe I			эну)	
On endin eath. or: Aft	Cartificata		1 X Natural 5 Pendii 2 Accident Investi	gation	, Day, rear)	njury	M 1 □	? Yes 2 ☐ No					
VISI or Atte ter de tirecte	Ţ		3 Suicide 6 Could 4 Homicide determ	inod 28e. Place o	f Injury - At ho		eet, factory, office		28f. Location (		nd Number or Ru	ıral Route Numb	er,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,			TV -	<u> </u>					W.				
Hosp 24 ho Fune eted f	Madical		(Check 2 ☐ Medical E	Physician: To the best Examiner: On the basis	of examinatio	n and/or invest	igation, in my opinic	n, death occurr	red at the time, date a	and plac	e, and due to the	cause(s) and mai	nner state
o the vithin o the	2		only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner: To	the best of m	y knowledge, d	29c. License		place, and due to tr		(s) and manner as ate signed (Mont		
		1	Distan 1	m,	D.		D0065	505			ine 11,		
4		(	30. Name and address of person	-		n 23a) (Type, P		,,,,,,,		J	111E 11,	2010	
1,5			Qiufang Cheng,	M.D., 990	1 Medi	cal Ce	nter Driv	re, Roc	kville, M	ary.	Land 208	50	
	tate	3	B1. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture							
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PINNIT I/ Rev /	12002	,											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TUNE 11:45P M WANDA LEE BARBER 2000 Medical Examiner Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENT GIEN BURNIE ANNE APUNDE Funeral If Under 7. Age (In vrs. last birthday) 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 - M 2 XXF Days Hours (Month, Day, Year) JUNE 22, 1944 Country) Director Yrs. 212.42.5865 65 MD Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 📈 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 215 BALTIMORE AVE. SW 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Completed by Black, White, etc. 1 Never Married 2 Married Yes 2XX No Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examore. If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: WHITE 3 XX Widowed 4 ☐ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **GROCERY CLERK** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GARRETT TRENT MARIE HILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHANNON KOOSER DAUGHTER 8 LENNON CT. , FERNDALE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Spec) GLEN HAVEN CEMETERY JUNE 16, 2010 GLEN BURNIE, MD 21. Sig atture of Funeral Service I 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. CRECORY FINK M01148 GLEN BURNIE CRAIN HWY. Enter the disease or heart failure. 23a. Part . shock plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Luria disease or condition resulting in death) ETASTATIC Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. physician and s the burial-transit STRUCTIVE YULMONARY DISEASE Exami that initiated events resulting in death) Last Physician/Medical that the death certificate be Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ fo in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: ျပ 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes Accident 2 🗆 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur MI and address of person who completed cause of death (Item 23a) (Type, Print) en Burne 31. Date filed (Month, Dak Ye State 32. Registrar's

DHMH 17 Rev 7/2009

Registrar

			Amend Item 1.  1 - State Registrar	Type or Pring 2 per fh.g: State of Ma	tin Bland ryland	ack Ir 7187 Depa	idelible In 2010dhb strijen of 1	k Ens 20c lealth	sure A เสเสโ	<b>II Copie</b> Iental Hy	s Ar	e Legibl e	e.	
						Cer	tificate of l	Death	TOUID		Reg. N	2010	18727	
	Physicia	in/	Decedent's Name (First, Middle, Last	,						2. Date of De		ay Yea	3. Time of Death	
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	land show	tor	10a. State 10b. County		10c. City, To	wn or Loc	cation						10d. Inside City Limits	
	Mary 28a-1 otifie	irec	Maryland Harfo	ord	Bel	Air							1 🗌 Yes 2 🛣 No	
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of What	Country?	
	ath w	nue	128 West Ring F	Cactory R 12. Was Decedent Eve		112 1/	21014 Vas Decedent of H	lianania O	riaia 2 /Coa	-if . Van an Na		S.A.		
9	er dez or ite	by F	1 Never Married 2 Married	Armed Forces?	0	I I I	Yes, specify Cuba	an, Mexica	ngin / (Specan, Puerto F	Rican, etc.)		14. Race - Ar Black, Wl	merican Indian, nite, etc.	
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an	be fil lental rked rc ev	욘	Richard Cooper							(First, Middle, Storme		Surname)		
ary	of and 2 should be file of Health and Mental H fitem 27 is marked of rother traumatic ever		19a. Informant's Name/Relationship (Type		1:	9b. Mailin	g Address (Street					r Town, State.	Zip Code)	
Σ	nd 2 s ealth a n 27 i ertra		Gene Cooper								_		and 21014	
ore	e 1 ar of He if iten		20a. Method of Disposition 1	Removal from State	20b. Place	of Dispos	sition (Name of natory or other place			ate		ocation - City		
ti	Pag tment tant: jury c		4 Donation 5 Other (Specify,	)		etHi	11Cemet	ery	6-11	<b>-10</b> -	Bus	tl, Ne	w York	
Baltimore, Maryland	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service License			22.	Name and Addres	ss of Facil	<sup>ity</sup> Mar	zullo	Fu	neral	Chapel, P.A	
		Н	23a. Part 1. Enter the disease, or compl	ications that caused th	oo dooth Do	<u>  6</u>	009Harf	ord	Road	1,Balt	imo	re,Ma	ryland 2121	
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.					s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68760	earn cernincate be attending physicial for use as the bur	Physician/Medical		i		-		-						
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<u>G</u> . :	gned t	9	Part II. Other significant conditions cor		not resulting	g in the ur	nderlying cause giv	en in Part	l.	23e. Did to	obacco i	use contribute	to the cause of death?	
ds,	quire; en siç	ted	prostite CAT				-	•		1 🗆	Yes 2	□ No 3 □	Probably 4 Unknown	
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<b>∑</b>	duing ruysician. The law h. After this certificate has funeral director, page 2.	<u>۵</u>	1  Yes 2 No	1 Inpatient		Outpatient . Time of		4 ∟ N					Assisted ecify Living	
0	th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Y	ear)	injury	28c. Injury work M 1		- 1	8d. Describe h	ow injur	y occurred		
Sio	after death	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury	- At home, f	farm, stree		163 2		8f. Location (S	Street an	d Number or F	ural Route Number,	
N N			4 Li Homicide determined	building, etc. (S	Specify)					City or Tow			and mode manned,	
	4 hour	edical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	cian: To the best of my	knowledge	e, death or	ccured at the time,	date and	place, and	due to the car	use(s) ar	nd manner as s	stated. e cause(s) and manner stated.	
4	within 24 ho To the Fune completed f	Σ∣	only one) 3 L. Certifying Nurse	Practioner: To the bes	st of my know	wledge, de	eath occurred at the	time, date	e and place	and due to the	e cause(s	s) and manner a	is stated.	
Ę	S		29b. Signature and title of certifier				29c. License					te signed (Mor		
		-	-	mploted access ( )	h /ltc 22 :	(T	033	25	5		101	ve 2,	2010	
			30. Name and address of person who co					1						
	State	e	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	ha	No-Phr.							
	Registra	r	JUN I 6 ZUT	1 Lesera	ø.	14000								

Birthplace (State or Foreign Country)

WHITE

21286

GREECE

1 □ Yes 🎖 □ No

21224

Approximate Interval Between Onset and Death

HOUR

30400

30 YUME

Day

2 🗆 No

10d. Inside City Limits

ΑМ

7. Age (In vrs. last birthday)

1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death

**Physician** /Medical **Examiner** 

Ε. CURTIS STEVE

Min.

JUNE

3. Time of Death 10, 2010 6:45

4a. Facility Name (If not institution, give street and number) 600 SUDBROOK ROAD 5. Social Security Number

4b. City, Town, or Location of Death PIKESVILLE

If Under 1 Year | If Under 24 Hrs.

Hours

4c. County of Death BALTIMORE

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. ral", or items 23a or 28a-f show Evan in wormust be notified at the Medical

traumatic permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Pages '

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Hospital or Attending Physician; The law requires that the death certificate be executed and attending physician for been signed the should be detailed certificate after death Director: completely filled in by the

P.O. Box 68760,

Division of Vital Records,

8. Date of Birth (Month, Day, Year) MAY 15, 1910 Months 1 X M 2 □ F Days 232-03-4566 100 Usual Residence of Decedent 10a. State 10c. City, Town or Location Directo MD. BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 SUDBROOK ROAD 21209 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS • College (1-4or 5+) CARPENTER CONTRACTING BUSINESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMANUEL S. KOURTIS ALFENOROULA PAULI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FEDRA CARMAN/DAUGHTER 1034 COWPENS AVE., TOWSON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/14/2010 BALTIMORE, MARYLAND OAK LAWN CEMETERY 21. Signature of Fune al Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the disea shock, or heart fai Immediate Cause (Fir al disease or condition resulting in death) nications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. MYOCA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 18 BAESTOSIS Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed DISAMALE Buch cong 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30408 address of person who completed cause of death (Item 23a) (Type, Print) A. warron WASHIN 100

'Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JUN 162010

24 hours a

within 2

32. Registrar's Signature

Amend #1 per MD G904 6/16/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:30 PM M Shelby Gooper Shelbe N. Cooper June 7 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 123 W. 29th Street N/A Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 03/19/1945 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2X F 213-42-4589 65 Maryland Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Experience must be notified at Director 1 XYes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29th Street 123 W. 21218 U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highes completed) Elementary/Secondary (0-12) College (1-4or 5+) retired Nursing vears Agencies Private Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ James Stanley Pearl Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shana Cooper(daughter) 1826 Harlem Ave., Baltimore, MD 21217 20b. Place of Disposition (Name of Joseph Prowing of the Place) Hand Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/14/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 30 Sephod F. of Brown Jr. Funeral Home P.A. weam 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) pertension /Medical Due or as a consequence of) Examiner iabe Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last holesterolenua be execut and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical 9 certificate the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery death 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed has been aw I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate 2 No 1 □ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 \( \sum \) (es 2 \( \sum \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) acreis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lace Baltimore, JENNE FLOWERS 31. Date filed (Month, Day 32. Regi State Registrar

DHMH 17 Rev 1/2001

10-04445 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dennis Joseph Carmody State of Maryland / Department of Health and Mental Hygiene 010 18730 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month **Medical Examiner** 2130 hrs DENNIS JOSEPH CARMODY June 11, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7825 Old Harford Road **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 X M 2 F 218-78-8936 49 6/17/1960 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No BALTIMORE PARKVILLE death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7825 OLD HARFORD ROAD 21234 USA Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married White, etc. 1 Yes imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If feath and Mental Hygiene.
ant: If feath and weart, the Medical Examiner in or other traumatic event, the Medical Examiner in 3 Widowed 4 Divorced If Yes, Give Year WHITE 1 Yes 2 Y No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CARPENTER SELF EMPLOYED 12TH GRADE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be MURRAY CARMODY LORRAINE KOLB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE CARMODY/MOTHER 207 ACORN CIRCLE APT. 101 TOWSON, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY, INC. 6/14/2010 CATONSVILLE, MD Donation 5 Other Specify: Signature of Funeral Service Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD21286 🚧 a. Part I. Enter the disease, 🗗 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line en Onset and /Medical Death Cardiomegaly Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that Due to (or as a consequence of) events resulting in death) Last and sician/Medical physician a X UNPENDED AMENDED 23a 27.per ME g905 7/29/10 TT The law requires that the death certificate be 3a. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth signed by the attending be detached for use as t 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted Records, page 2 should certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Com ✓ Yes 2 1 🗸 Yes or Attending Physician; after death. director, 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other; Nursing Home 5 Residence 6 Other; Scene this 1 🗸 Yes DOA funeral After 27. Manner of Death 28a, Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division 5 Pending 1 Yes 2 No To the Funeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 📗 6 Could not be Suicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

To the Hospital within 24 hours at

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

29b

Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year,

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Borera

30. Name and address of person who completed cause of death (Item 23a)

2 🗹 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 12, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inda Diane Co		1- For State Registrar	S	tate of Maryl		artment o e <i>rtificate o</i>		Mental H	Hygiene	Reg. No.	20	0 1873	3
Physic Medical Exam		Decedent's Name							2. Date of Do Month	Day	Year	3. Time of Death	-
win w	mie	LINUA DIA	ne Colo	on, give street and n	umber)		4b. City, Town, or L	ocation of Dea	June 9,		County of D	1101 hrs	
		Southern Ma			,		Clinton			1	rince Geo		
Funeral		5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24H		Birth(MM/D	DD/YYY) 9	Birthplace (State or	_
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the M a or 2 tified	Director	1222 Gile	s Rd #	1030			79915			Ü	USA	,	
72 hours after death with the Maryland n "matural", or items 23a or 28a-f sho al Examiner must he notified at once,	Funeral	11. Marital Status		12. Was Dec	cedent Ever in U		s Decedent of Hisp	anic Origin? ( S	Specify Yes or N	lo- 1	14. Race - Ar	nerican Indian, Black,	_
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5-0036 led within 7/ Hygiene. other than	фш	12		3		Sale	s Rep				Reta	ail .	
		17. Father's Name (	First, Middle	, Last)				Mother's Nam	e (First, Middle	Maiden S			_
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MOI Pages ent of int: If		1 Burial 2 x	_	n 3 Removal fr	om orace	crematory or other	nerpuace) nes Cremati	on June	e 14, 201	0 511	ınland P	PL NM	
Baltimore, permit. Pages 1 at Department of He. Important: If ite		21. Signature of Fun			-	) 22 N	ame and Address o	f Facility		<u> </u>	in rang t	K , 1111	-
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Physician /M i		lallure. List only	Voue and	on each line.			ne mode of dying, su	uch as cardiac o	or respiratory a	rest, shoc	k, or heart	Approximate Interv Between Onset an	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Functal Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transit								•			_		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 V M	ledical Exan	niner: On the basis o	f examination a	nd/or investigation	on, in my opinion, de	eath occurred a	at the time, date	and place	and due to	the cause(s)	
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10		114 C		11/1	D		O.C.M.I	E.		June 1	10, 2010		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SHIRLEY D CHARIK JUNE 20ÎÖ 4:54 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death ATRIUM VILLAGE OWINGS MILLS BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 🗆 M 2 🕇 F Months Days Hours Min. 0571671926 212-26-2496 84 Director MD Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #474 21117 USA death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give "natural", 3 X Widowed 4 □ Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL BILLING MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAND HILDA WOLFSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD CHARIK/SON GREENWICH PLACE, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury BETH EL MEMORIAL PK. 4 Donation 5 Other (Specify) 6/15/2010 RANDALLSTOWN, MD 21. Sign ture of Funeral Service Linens 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su a sa cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physiciani YPa disease or condition resulting in death) IMENTI Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Month Day Year the detached g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy certificate performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 100433 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 203 PALTIMORE, MD 21209

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 8,2010 Bienvenido Escalona June 2:35 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Rehabilitation Ellicott City Howard 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) August 8,1934 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Director 586-60-3925 75 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 23a or 28a-f Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 6515 Frederick Road 21228 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married  $\frac{1955}{1961}$ 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 Specify: Filipino 1 ☐ Yes 2X☐ No Specify: "natural", Completed 3 Widowed 4 Divorced th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fortonato Escalona Loreta Custodio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau Anna Emmons - Daughter 6515 Frederick Road, Catonsville, MD 21228 28a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Devrial 2 Cremation 3 Removal from State cenneters cremetory of other place) ation 5 Other (Specify) 4 🗆 pd Crematory Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure, List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VER CANCER Sequentially list conditions. If any, leading to immediate Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA Division of Vital Records, 1 Tes 3 Probably 4 Unknown LIVER FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death?
1 Yes 2 No After this certificate To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifica director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Hospital: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 205 catousulle MO 516N 00 State Registrar

10-04370
Lakia Epps

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lakia Epps		State of Maryland / Department of Health a  1- For State  Certificate of Death	and Mental	Hygiene	201	18731
Physici	an/	Registrar Certificate of Death		2. Date of De	Reg. No.	3. Time of Death
Medical Exami				Month June 8, 2	Day Year	2155 hrs
			n, or Location of D		4c. County of De	ath
		Good Samaritan Hospital Baltimore	a			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 N		4Hrs. 8. Date of E	Birth (MM/DD/YYYY) 9.	Birthplace (State or
Director		212 94 4106 <sub>1 M 2</sub> 30 <sub>Yrs.</sub> Months 5	Days Hours	Min. Sept	.21,1979For	Country)
y.		Usual Residence of Decedent				
ow an		10a. State 10b. County 10c. City, Town or Location 10b. MD Baltimore	-Co.			10d. Inside City Limits
yland Person	tor	Baltimore				1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1707 Red Oak Rd.	1234		10g. Citizen of What Co USA	ountry?
h with	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of				erican Indian, Black,
r death	Fun	1 Never Married 2 Married Armed Forces? If Yes, specify Cul	ban, Mexican, Pu	епо Rican, etc.)	White, etc.	
s afte rral",	þ	or Dates:	No specify:			lack
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occu during most of working to the complete of the comp			16b. Kind of Busines	s/Industry
36 hin 73 than edical	ple	l yr. Nurse Assi	stant		Nursing	Home
215-0036 be filed within 7 ttal Hygiene. *ked other than ent, the Medica	Con	17. Father's Name (First, Middle, Last)	18.Mother's No	ame (First, Middle,	Maiden Surname)	
21215 uld be file Mental H marked o	o Be (	David Epps	[ Char]	lene Mc	Coy	
MD 2 d 2 shoul th and N a 27 is m umatic	ĭ	19a. Informant's Name/Relationship (Type, Print) Charlene McCoy (mother)  19b. Mailing Address (St	reet and Number UCKY 7	or Rural Route Nu Ave. Ba	mber, City or Town, Sta 1 to, Md. 2	te, Zin Cade) I 213
Te, land I and Titem		20a. Method of Disposition  1 K Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of crematory or other place)	cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: King Mem.Pk.	Jı	ine 18,	2010 Balt	o,Md.
alti mit. partm porta		21. Signature of Funeral Service Licensee 22. Name and Addre	ess of Facility			
E E E B		11412 F	Presto	on St	neral Hom Balto Md	e 21213
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.	ng, such as cardia	ac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Non-Ketotic Hyperglycemia	1			Death
*		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b.				
	ē	if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):				
mist de de		d				
60, to be executed ysician and burial - transit	edical	X UNPENDED X AMENDED #10b, perFH, G904, 6/16/10, WS	8-3-10 v	vt		
6876( certificate rding phy-	<b>∑</b> I	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	
. Box 6876 he death certificate y the attending phy hed for use as the t	0	past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	3Ectopic preg	gnancy	Month	Day Year
Box e death o	(A)	1 Yes 2 No 9 V Unknown 9 Unknown				
O. nat the d by t etache	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e, Did t	obacco use contribute t	the cause of death?
s, P.O. iires that the signed by i	ğ b			1 Ye	s 2 No 3 Pro	obably 4 Unknown
ords, w requir	jet			24a, Was autor		utopsy findings available completion of cause of
ecc he lav	Completed				rmed?   death?	
an: T	Be C	25. Was case referred to medical 26.Pla	ace of Death (Che		2 10	2 10
Vital Records hysician: The law requi this certificate has been	0	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA	Other Nur	sing Home 5	Residence 6 Oth	er:
1 of Jing Ph	<b>⊆</b> I		njury at Work?	28d. Describe	how injury occurred	
ion itendi leath.	랿		Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requints after death.  "al Director: After this certificate has been so led in by the funeral director, page 2 should be an in the funeral director, page 2 should be a sho	rtificatio	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	building, etc.	28f. Location ( or Town, S		ural Route Number, City
Spital spital neral	8	4 Homicide determined (Specify)		G. Tomi, C		
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the temperal process.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion				
To wit	ĕ	and manner stated.	nse number		29d Date signed (Mo	
		11/1 / / 540	C.M.E.		June 9, 2010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
4	ŀ	30. Name/and address of person who completed cause of death (Item 23a)				
$\varphi$		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, M	D 21201		
Sta	te	31. Date (Jack) 32. Registras Signature				
Registr	ar	JUNI I U CUIU COMO P. GANGE				

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daquan Eggleston State of Maryland / Department of Health and Mental Hygiene 010 18735 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Medical Examine Daquan Eggleston 1311 hrs June 12, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 213-47-9903 Months Country) Director Davs Hours 14 1 X M 2 F 04/<del>02</del>/1996 Maryland Usual Residence of Decedent пy 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Dundalk 1 Yes 2 XNo Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 23a or 28a-f g 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1937 Frames Road 21222 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Black If Yes, Give Yea 4 Divorced 1 Yes 2 X No specify: ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 7th Student Public School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) Andre Eggleston Shavette Conigland 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shavette Conigland (mother) 1937 Frames Road, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) St. 6/26/2010 Stanislaus Dundalk, MD 4 Donation 5 Other Specify: Signature of Funeral Service Licenses 22. Name and Address of Facility Phillip A. Weatherford er Street, Baltimore MD Oliver Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical a. Drowning Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical AMENDED #8perFH, G904, 6/29/2010, WS After this certificate has been signed by the attending physician in functal director, page 2 should be detached for use as the burial UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: 1 V Yes No 27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural FOUND: Subject drowned filled in by the fi Pending 1 Yes 2 V No Jun 12, 2010 1230 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2057 Inverton Road, Dundalk, MD determined (Specify) Creek 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 13, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 12 HARRIET EISNER 2010 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ONE SLADE AVENUE, #506 BALTIMORE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Months Days Hours Min. 0470571922 **Director** 028-16-0022 88 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ONE SLADE AVENUE, #506 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married Completed by 1 ☐ Yes 2 X No Specify: WHITE Specify 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry HARRIET SAUBER EISNER (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STUDIO OF THE DANCE OWNER Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ FREEMAN SAUBER HELEN NATHAN Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 KERNEWAY, BALTIMORE, MD STEVE EISNER/SON Baltimore, 20b. Place of Property of other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD AITZ CHAIM CEM. 06/15/2010 Qonation 5 Other (Specify) Signature of Funeral Service Lio 22. Name and Address of Facility Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD INC. 21208 Part 1. Enter the disease, or shock, or heart failure. List plications that caused the cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final ancreat Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2: autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

jusan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:12P Doris Forrester 2010 66 Medical 4a. Facility Name (if not institution, give street and number) Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Baltimore University of Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. (Month, Day, Year) 11/27/1923 1 □ M **X**X F Days Director MD Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director N/A MD Baltimore Yes 2 No ö 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral 1464 Woodall Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Force ģ 1 Never Married 2 Married Yes 2XXNo Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Completed 3 ₩widowed 4 □ Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Rusiness Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Newman Mary Zang permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Mary Theresa Forrester / Daughter 1464 reet and Number or Rural Route Number, City or Town, State, Zio Code) WOODALL Street, Baltimore MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery 6/21/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) e of Fune al Service Licensee Victor P. <sup>22</sup> Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Avenue, Baltimore MD 21230 21. Signa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final erebrovas cultr Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury physician and the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No for Month Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AtriAL FIBRILLATION Records, 2 No Completed 3 Probably 4 Unknown as been signal to the state of 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? certificate ha 2 No 1 Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) injury 5 Pending after death. М 1 Yes 2 No Accident Investigation Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P22980 6/15/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 South Greene Street Baltimore

DHMH 17 Rev 7/2009

State Registrar 22

ennie 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9906 8-9-10 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 45 M ANITA FARDELMANN Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNINSULLY Vilanic 30413641K4 Funeral Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - XX MARonth, Day, Months Days Hours Min Director 525.36.7821 84 IOWA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No BRADFORD ROME 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral RR 1 BOX 105 F 18837 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XX No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 IONA ELLIS SAMUEL McMAHON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUSBAND RR1\_BOX 105 F ,ROME, 18837 DONALD C. FARDELMANN PΑ 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Fremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crer 2010 MAY 30, ATHENS, PA 21. Signal e of Funeral Service Licer Name and Address of Facility CREAORY FINK FUNERAL HOME, M01148 FINK CRAIN HWY BURNIE MD 23a. Part 1. shock, nter the diseas r heart failure. I lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause a each line. Immediate Cause (Final Physician/ disease or con tion resulting in death RAL-Medical e of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year 2 No g Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **To the Hospital or Attending Physician:** The law requires within 24 hours after death. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performed? Yes 2 No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Investigation 1 Yes 2 🗌 No To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

10-04220	
Olga Arotinco	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		rtificate of			Reg. No.	
Physic Medical Exam		1. Decedent's Name (First, Middle,	ent's Name (First, Middle, Last) Olga Consuelo Arotinco Gaspar					3. Time of Death 1030 hrs
1		4a. Facility Name (if not institution,			. City, Town, or Location of	June 3, 2 Death	4c. County of Dear	
		10801 MacArthur Boule			Potomac		Montgomery	
Funeral Director		5. Social Security Number 100		• • • • • • • • • • • • • • • • • • • •	If Under 1 Year If Under Months Days Hours	Min	irth(MM/DD/YYYY) 9. Bi Fore	an
		Usual Residence of Decedent	M 22F 3	O Yrs.		5-19	1-74 0	ountry) Peru
any		10a. State 10b. County	10c. City	, Town or Location	1		-	10d. Inside City Limits
Maryland 28a-f show 1 at once,	    -	VA Fairf	ax	Herno	don			1 Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	intry?
ith the Maryland 23a or 28a-f sho notified at once		2108 monage			20170		Peru	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marr	ied   12. Was Decedent Ever in U		Decedent of Hispanic Origii , specify Cuban, Mexican, I		o- 14. Race - Ame White, etc.	rican Indian, Black,
ifter de		3 Widowed 4 Divor	1 Yes 2 No	1 💹 Y	es 2 No specify:	Peruvian	Specify: U	shite
hours a	ed by	15. Decedent's Education (Specification)			Usual Occupation (Give kit of working life, DO NOT u		16b. Kind of Business	/Industry
2 -	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		abor		Prut	
5-00 led with tygiene other	Com	17. Father's Name (First, Middle, L	ast)			Name (First, Middle,		
	Be	Nicanor Aro	tinco Huan	nan	Jac	inta G	raspar	
MD 2 d 2 should lth and M n 27 is m.	7	19a. Informant's Name/Relationship  Juan Escalant			ddress (Street and Numb	er or Rural Route Nu	mber, Cit or Town, State	
Z pd 2 Pd 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2		20a. Method of Disposition	20b.	Place of Disposition	Managhov	Date Date	20c. Location - City of	ZOL /O Town, State
nor Pages l at: If other		1 Burial 2 Cremation 4 Donation 5 Other Spec		crematory or other	Crematory	6-11-10	Duredal	o MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Lie	censee	22. Nar	ne and Address of Fao ity	A. Sandy	ers & sons	mortuary
	_	fine / le	no	(33	29 Woodbr	idge St,	Woodbridge	VA 22191
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or	each line.	. Do not enter the	mode of dying, such as car	diac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Drowning  Due to (or as a consequence or	f):				Death
	L.	Sequentially list conditions,	b	•				
	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence o c.	f):				
ted nsit	Examin	events resulting in death) Last	Due to (or as a consequence o	f):				
760, icate be executed physician and the burial - transit	ical	UNPENDED	x AMENDED 1 per	me g907	9-17-10 vt			
68760, ertificate be ding physic e as the bur	Medica	IF FEMALE:	23c. If yes, outcome of preg	nancy			23d. Date of deliver	у
OX 68 eath certifi attending for use as 1	/sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth  4 Pregnant at time of de	2 Fetal	death 3 Ectopic p	regnancy	Month I	Day Year
Box e death c the atten ed for us	Physi	1 Yes 2 No 9 V Unkno		□ Otner	(Specify)		1	
P.O. es that the igned by	by P	Part II, Other significant condition	s contributing to death but not re	esulting in the und	erlying cause given in Part		obacco use contribute to	
IS, P.C quires that en signed uld be deta							s 2 No 3 Prot	oably 4 Unknown
COFC Law re has be	Completed					autor		completion of cause of
tal Recian: The certificate ector, page		25. Was case referred to medical			OS Place of Davids (O	1 ✓ Yes	2 No 1 Y	es 2 No
/ital ysician nis cert directo	b Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (C	lursing Home 5	Residence 6 V Other	: Scene
ing Ph After t uneral	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injur	y 28c. Injury at Work?		how injury occurred	
sion ttendi death. ctor:	cation:	Natural 5 Pending  2 ✓ Accident Investig	ation Jun 3, 2010	FOUND: 1000 hrs	1 Yes 2 V N	o Subject fell/	Jumped into river	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sided in by the fineral director, page 2 should be a by the fineral director.	Certific	3 Suicide 6 Could n		ome, farm, street, f	actory, office building, etc.	or Town, S	Street and Number or Ru State) ark, Great Falls, VA	ral Route Number, City
Di Hospital 14 hours a Funeral I ely filled	ဦ	4 Homicide  29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	ge, death occurred	at the time, date and place			ed.
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical		er: On the basis of examination ar					
L > F 2	ž	29b. Signature and title of certifier	/-		29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		Mulen	aul MS		O.C.M.E.		June 4, 2010	
		<ol> <li>Name and address of person wh Melissa Brassell, MD</li> </ol>	o completed cause of death (Item Assistant Medical Examin	,	n Street, Baltimore,	MD 21201		
St	ate	31. Date filed (Month, Day 144)	6 201 32. Registrar's Signatu	20 4	all of			<del></del>
Regist	rar	JUN	0 EALA \0.	<i>▼ M</i>				

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/lina Green			te of Maryland / Depa			Hygiene	2010	18740
		1- For State Registrar		rtificate of	Death		eg. No.	10770
Physici		Decedent's Name (First, Middle, I				<ol><li>Date of Dea Month</li></ol>	Dav Year	3. Time of Death
Medical Exami	ner	Vina Trea				June 14, 2		0438 hrs
		4a. Facility Name (if not institution, Fort Washington Hospit		44	o. City, Town, or Location of De Fort Washington	ath	4c. County of Death Prince George	
				In at high days		In In Date of Die		
Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24 Months Days Hours M	Ain. Date of Bir	th(MM/DD/YYYY) 9. Bir Poreig	in 1/a
Director		118-80-4142 1	M 2 X F	4/ Yrs.		09/2	7//768   00	untry) <b>y</b> $u$
ž.		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location				10d. Inside City Limits
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Varyland 28a-f show d at once.	tor	MD Prince	uwiges For	rt Mus	phington			•
Mary r 28a ed at	Director	10e. Street and Number	1, 1, 1	1 71	10f. Zip Oode	1	Og. Citizen of What Coul	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.		1200 Jaywic	K Avenue Ap	T. 104	20144		USA	
th wi	Funeral	11. Marital Status  1 Never Married 2 Marr	12. Was Decedent Ever in U Armed Forces?		Decedent of Hispanic Origin? ( s, specify Cuban, Mexican, Pue		<ul> <li>14. Race - Ameri</li> <li>White, etc.</li> </ul>	can Indian, Black,
or dea	Fu		1 Yes 2 No	1, ,	res 2 X No specify:		BI	ack
72 hours after death with the Maryland n "natural", or items 23a or 28a-f shr al Examiner must be notified at once	by	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ced If Yes, Give Year or Dates:		Usual Occupation (Give kind of	of work done	Specify: 16b. Kind of Business/I	ndustry
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15-0036 filed within 7. I Hygiene. ed other than t, the Medical	Completed	17. Father's Name (First, Middle, La	ist)	Lopus	18.Mother's Na	me First, Middle, M	faiden Surname)	· · · · · · · · · · · · · · · · · · ·
	Be C	Billie Charles.	Davis Sr		Mahl	0 (100)	and	
2121 wld be fi Mental marked c event,	To E	19a, Informant's Name/Relationship		19b. Mailing A	Address (Street and Number of	or Rural Ro e Num	ber, City or Town, State	, Zip Code)
MD d 2 sho lith and n 27 is sumati		Mable Hutton	1 Mother	5304	Harford Road	RaHin	love. Maryle	ind 21214
_ = 9 5 5		20a. Method of Disposition	,		on (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite			3 Removal from State	crematory or othe	r piace)	22/10	Rollinge	Maryland
Baltimo permit. Page Department of Important: injury or ott		A Signature of Funeral Scholer Spec	A COLUMN TO A COLU	100 C	me and Address of Facility	<del>- 10</del>	ACT VS. K. D	That is like the
Balti permit. Departi Import	ı	(7)	554	Vau	ahn C. Aroone	5 型	S lork A	aryland 21212
Physician	$\exists$	23a. Part I. Enter the disease, or co		n. Do not enter the	phode of dying, such as cardiac	or respiratory arre		roximate Interval
∼ lM∈ diral		failure. List only one cause on		Condiens	nacular Digagg	^		Between Onset and Death
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Box 6876 death certificate the attending phy of for use as the l	an/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth		death 3 Ectopic preg	nancy		ay Year
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Be dez	2		a qukupwu			100 0:11	1	
P.O.	by F	Part II. Other significant condition	-	-	lerlying cause given in Part I.		bacco use contribute to t	
S, P.C uires that n signed d be detz		<u>Chronic React</u>	ive Airway Dise	ease				
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Division of Vital Records, tat or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed					perform 1 ✓ Yes 2		s 2 No
Vital Rec ysician: The l his certificate b	οl	25. Was case referred to medical			26 Place of Death (Chec	k only one)		
Vita ysicis ysicis direci	OB O	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Qutpatient	DOA Other Nurs	sing Home 5 1	Residence 6 Other:	
1 of Jing Ph	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe h	ow injury occurred	
ion tendin eath. for: A	흥	1 X Natural 5 Pending			1 Yes 2 No			
/iSi r Att ter de irecte	ᆲ	2 Accident Investig 3 Suicide 6 Could no	28e Place of Injury - At hi	ome, farm, street,	factory, office building, etc.		treet and Number or Rur	al Route Number, City
District of Ited in It	Certification:	4 Homicide determin				or Town, St	ate)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		202 Codifier	ician: To the best of my knowled	ge, death occurred	d at the time, date and place, ar	nd due to the cause	e(s) and manner as state	d.
o the ithin ;	Medical		ner:On the basis of examination a and manner stated	nd/or investigation	n, in my opinion, death occurred	d at the time, date a	and place, and due to the	cause(s)
F 3 E 8	₩	29b. Signature and title of certifier	and margini stated		29c. License number		29d. Date signed (Mon	th, Day, Year)
		antiz	>		O.C.M.E.		June 15, 2010	
	ŀ	30. Name and address of person wh	o completed cause of death (Item	1 23a)				
				111 Penn Str	eet, Baltimore, MD 2120	01		
St	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signatu	ire A. A	arket			
Regist		.IUN 1	6 2010 Leavenin	L. 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GREEN Day Vear Month ZONIA JUN 06.08 AM 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia **Howard** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗹 Months Days Hours Yrs 147-24-5028 Mar 15, 1935 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🗹 No MD Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6528 Frietchi Row 21045 U.S.A. 12. Was Decedent Eyer in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Dever Married 2 Married 2 No 1 🗌 Yes Specify: 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Will Jones Metter Stroman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Washington 6528 Frietchi Row Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State

and attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ned by the a signed b has been eral Director: After this certific filled in by the funeral director, within 24 hours after death. To the Funeral Director: A

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

Director

28a-f show

"natural", or items 23a or 28a-f sho

er than "natur the Medical I

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once.

Physician/ **Medical** Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	1 M Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	• •	emorial Gardens	Jun 18, 2010	Pines	. NC					
	21. Signature of Funeral Service Licensee		me and Address of Facility	ome, P.A. bia Pike Ellicott Cit		,					
	23a. Part 1. Enter the decase, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death)  a	rew	Approximate Interval Between Onset and Death Figure 1445								
Completed by Physician/Medical Examiner	Esquentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or a Due	FEW YRS									
/Medica	IF FEMALE:										
nysician	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23d. Date of d Month	delivery Day Year								
ted by PI	Part II. Other significant conditions contributing to death  DEMENTIA,  E		e to the cause of death?								
Comple	HTN.	prior to d? death?	autopsy findings available to completion of cause of n? Yes 2  No								
Be	25. Was case referred to medical examiner?		26. Place of Death								
0	Hospital:	tient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursi	ing Home 5  Residence	e 6 🗆 Other (Spe	ecify)					
Certificate:	27. Manner of Death  1	ay, Year) injury	28c. Injury at work? 1  Yes 2  No	28d. Describe how							
	4 ☐ Homicide determined 28e. Place of Ir building, €	tate)	or Rural Route Number,								
Medical	(Check 2   Medical Examiner: On the basis of only one) 3   Certifying Nurse Practioner: To the	(Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner s									
	29b. Signature and title of certifier	no	Doc 62634		Date signed (Mon						

State Registrar HICKINY RIDGE RD

CILUM31A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10796

32. Registrar's Signature

MATERN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2010 1636 p GREGORY HALL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours May 20, Year 958 52 **Director** 578-76-2499 NC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2X No MD Riverdale Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 5907 Lafayette Ave. 20737 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bus Operator 12th Metro other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James E. Hall Lillie M. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Wilson Hall-Wife 7319 Avenue Hyattsville, MD. 20783 17th permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington 6-22-2010 Adelphi, MD. Signature of Funeral Şervice Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GLIOBLASTOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ULMONA? Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No the g Unknown detached 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEIZURE SORDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No death?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29d. Date signed (Month, Day, Year) 2010 ath (Item 23a) (Type, Print) Name and address of person who completed caus

State Registrar 31. Date filed (Month, Day, Year)

7600

Registrar's Signature

CARROLL AVE -

MD

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:00 PM Betty Lee Hartsock 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tarre Grace 10 Social Security Numbe If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV 1 □ M 2 💢 F Months Hours 08<sup>M</sup>978, Dry 23 Director 235-36-0098 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 IISA 22 Dallam Ave Page 1 and 2 should be filed within 72 hours atter dearn w ment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items; uny or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles Ellis Ethel Shingleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Dallam Ave Bel Air, MD 21014 Sally Slade (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o Department of 1 XBurial 2 Cremation 3 Removal from State BelAir Mem. Gardens 06-15-2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servix Lica see 22. Name and Address of Facility Schimunek Funeral Home of BelAir MOIRZ Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final 20nset and Death 1 dralion Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 2 ruks Examiner almutuliar Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wham 032600 110 14/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Revolution St Harrede Grace MD 2184 Kannidy Militari 1106 31. Date filed (Month, Day, Yes 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM# SperFH, G904, 6/22/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMFND TTFM#7perFH, G904, 6/25/10, WS Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10 Day 2010 ear Jume Norris Carrol1 Hekimian 11:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery 5. Social Security Number 8. Date of Birth 4 (Month, Day Yea January 12; 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Min 577-30-4407 Washington, D.C. Director 84Yrs 1926 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9903 River View Court 20854 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 K Yes 2 No
If Yes, Give WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by 1 Tes 2 No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nejib Hekimian Louise Von Andrian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher D. Hekimian /Son 18396 Porterfield Way, Potomac, Maryland 20854 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. June 16, 2010 | Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Mongomery Avenue, Rockville, Maryland 20820-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Cardiac Arrest Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Subdural Hematoma Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 No 2 No Hospital Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? Virthin 24 hours after death.

To the Funeral Director: After the funer. 28d. Describe how injury occurred 1 Natural
2 X Accident May 8, 2010 injury 5 Pendina 1 🗌 Yes 2 🏝 No Fell at Home Unk Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of Paral Route Number of Town, State) ct determined building, etc. (Specify) Home Dana C mo 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica) Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) June 11, 2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878 Raman R. Tali, M.D 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010Robert S. Hoff June 9 7:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Yea March 12, 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F Hours Year) Country)
Illinois Director 460-18-2822 90 Yrs. 1920 March Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 520 Russell Avenue 20877 United State 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Examiner 14 Bace - American Indian Armed Forces? Black, White, etc. Completed by 2 No 1941-1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 Divorced 1946 Year or Dates. item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephen C. Hoff Ethel Munger and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol H. Alford/Daughter 591 Ridgeland Farms Road, Montgomery, Alabama 36105 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ament of I permit. Page 1
Department of I
Important: If it
any injury or or Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 16, 2010 Bethesda, Maryland 21. Signatura of Funeral Service Lic Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Haran M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition **∖** Medical resulting in death) Due to (or as a consequence of) Examiner mp Sequentially list conditions, Examine frank, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of 0 **Hospital or Attending Physician:** The law requires that the death oertificate be executed 24 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Subdural Hematoma 1  $\square$  Yes 2  $\overline{\mathbf{X}}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Chronic Kidney Disease autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 □XYes 2 🗆 No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 🔀 No ☐ Natural X Accident 5 Pending May 2, 2010 neral Director: A Investigation Fell at Home Unk 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 520 Russell Avenue determined Gaithersburg, Maryland within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 2010 D0062435

12/

State Registrar 10110 Molecular Drive #2, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Elsayyad,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Month A. 12 9:00pmM Mary Henderson June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🛣 F 230-40-1051 80 Director Aug. 10. NO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Ashland Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Daycare Provider Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dewitt Henderson Bertha Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nakia Dorman/Granddaughter Baltimore, N Robinson St 21205 Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) iJune22 Cemetery OBalto on21. Signature of Funeral Service Lice 22. Name and Address of Facility SCRUGGS FUNERAL PRESTON ST. BALTO ALVIN В 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Death Immediate Cause (Final Physician/ disease or condition CORDIDERCINO Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? **Director:** After this certificate I 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1  $\square$  Yes 2 🗀 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🔽 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi

State Registrar 2130

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ų	For	State	of Mar		•			Ith and M	lental Hy	giene	)			
									Reg. No	g. No. 2010 87			47			
Physi		_	<ol> <li>Decedent's Name (First, Middle CHARLES ELMER HOBU</li> </ol>	,							2. Date of De Month MAY		y 2010 Ye	ar	3. Time of D 845	eath a M
	edica mine		4a. Facility Name (if not institution,		mber)		4	b. City. Tow	n. or Loca	ation of Death	11/11		. County of I	Death	043	a
			2518 HOBBITS LANE					,		NV1LLE			ANNE AF		L	
Fune		1	5. Social Security Number	6. Sex 1 🔀 💥 2 🗆 F	7. Age (Ir	yrs. last birth	- 1)/ N	If Under 1 Ye	ar If U	Inder 24 Hrs.	8. Date of Bir (Month, Da		g.	Birthp Count	lace (State or i	Foreign
Direct		-	160.12.3472 Usual Residence of Decedent	**************************************		92	rs.		,,		SEP. 8,	1917		PEN	ÍNSYLVAN I	Α
and show		. It	10a. State 10b. County		10	Oc. City, Town	or Locati	ion						11	0d. Inside City	Limits
Maryla 28a-f		ec c	MD ANNE	ARUNDEL		DAV	IDSON	IVILLE							1 ☐ Yes 2	2 <b>XX</b> No
the a or 2	1		10e. Street and Number		•			10f. Zip Cod	le			10g. Ci	tizen of Wha	t Coun	try?	
th with ms 23 must		Funeral Director	2518 HOBBITS LANE					2103					USA			
or iter	l l	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marr</li></ul>	12. Was Dec Armed Fo	orces?		13. Was	s Decedent of es, specify C	i Hispani uban, Me	ic Origin? (Spec exican, Puerto F	city Yes or No- Rican, etc.)		14. Race - A Black, V			
S after rall, of Exan	:	ᄝ	3XX Widowed 4 □ Divorced	1637	2 $\square$ No ve ates. 19	42 <b>-</b> 45	1 🗆	Yes 2 🗓	(No Spi	ecify:			Specify:	WHIT	E	
2-003 2 hours aft "natural",		Completed	15. Deceder (Specify only highe	t's Education		16a.	Decedent	t's Usual Oc	cupation ne during	most of workir	na	16b. K	ind of Busin	ess ind	ustry	
thin 7	<sub>/</sub>	Ĕ l	Elementary/Seconday (0-12)	College (	1-4 or 5+)		life. DO N	VOT use retii STRATIV	red)				VERSITY		PITTSBUR	
C A led wi Hygir other		ωŀ	12 17. Father's Name (First, Middle, L	ast)			ואוואט	SIRAII	$\overline{}$	Mother's Name	(First, Middle,			ואט	TAL MED	CINL
ITE, MISTIFICAL ZICIONOSO  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The man is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	١,	의	LELAND E. HOBURG							MARY LY	DA McELH	ANEY	,			
should and N is ma			19a. Informant's Name/Relationsh	ip (Type, Print)		19b.	Mailing A	Address (Str	eet and N	lumber or Rurai	l Route Numbe	r, City or	Town, State	, Zip C	ode)	
und 2: health m 27		-	PAUL D. HOBURG		SON			IOBBITS			SONVILLE					
Page 1 anent of Hant or ot ot ot ot ot ot ot ot ot ot ot ot ot		ľ	20a. Method of Disposition 1				y, cremato	ory or other		1	ate		ocation - Cit			
permit. Page 1 Department of Important: If i any injury or or		+	4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service I.		-0	MT. LEB	-	CEM.	dross of E		, 2010	PIT	TSBURGH	l, P/	4	
permit. Departr Importa	ouce.		K. GRECORY	FINK	MO	1148	F	INK FU	IERAL	HOME, P.		E MD	21061			
			23a. Part 1. Enter the disease of shock or heart failure. List of	complications that	caused the	e death. Do no							2.1001	1	Approximate Interval Between	oon
Physicia	1117	-	Immediate Cause (Final disease or condition	to one cause on e	I	eme	nti	a							Onset and De	eath _
Medic	_	-	resulting in death)	a. Due to	(or as a co	onsequence o		-							7 7 50	
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attence for us	[.5	Pnysician/me	23b. Was decedent pregnant in the past 12 months?	1 Live	Birth 2	Fetal death		ctopic pregr					23d. Date o Month		ry Day Ye	ar
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g Phy erthis neral c			27. Manner of Death	28a. Date		28b. Ti		28c. l	njury at		28d. Describe			респу		
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or Att ifter de Directe		Certificate:	3 ☐ Suicide 6 ☐ Could at 4 ☐ Homicide determ	ned 28e. Place	of Injury - ing, etc. (S	- At home, fari Spec <i>ify)</i>	m, street,	, factory, offi	ce	1	28f. Location (\$ City or Tox			Rural	Route Number	;
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	13	ਜ਼ <u>-</u>	29a, Certifier 12 Certifying	Physician: To the I	oest of mv	knowledge, d	leath occi	ured at the t	ime. date	and place, and	d due to the ca	use(s) ar	nd manner as	state	<u> </u>	
ne Hos n 24 h ne Fur pleted	100	Med	(Check 2 Medical E	xaminer. On the ba Nurse Practioner:	sis of exam	nination and/or	investiga	tion, in my o	oinion, dea	ath occurred at	the time, date a	and place	, and due to	the cau	se(s) and manr	er stated.
To the comp	"		29b. Signature and title of certifier						ense num			-	te signed (M	1	_	
			1 hai	2/1	m			$\square D$	550	495		Ju	ne	1,	2010	
1			30. Name and address of person w	ps, MO	se of death	(Item 23a) (T	ype, Print	is ch	snce	R.d	Edge wa	ter	, m.	2	2103:	<del>}</del>
S Regi:	State strar		31. Date filed (Month, Day, Year)  JUN 1 6 2010	Beneva 32. F	Registrar	Signature	الما									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06/16/ Richard W. Jordan 4:30 a м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5845 Bellanca Dr. Elkridge Howard 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Hours Country) **Director** 168-22-1992 PΑ 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Funeral Director MDHoward Elkridae 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? items 23a 5845 Bellanca Dr. USA 21075 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

\*\*XX\*Yes 2 \sum No If Yes. Give 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 946-1948 Specify: White "natural" 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ဂ္ Edgar R. Jordan, Sr. Charlotte Saxton and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Buswell / Daughter f Health 5845 Bellanca Dr., Elkridge, MD 21075 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 06/19/2010 Hillview Cemetery Greensburg, PA 4 Donation 5 Other (Specify) . Signature of Funeral Septice Lice 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, 4023 Annapolis Road, Halethorpe, MD 21227 M01452 Mark 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner VANCEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran nding physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) tor: After this certificate has been signed by the a the funeral director, page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, X No 3 Probably 4 Unknown Be Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one, 2 Other: No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗆 Nu<u>rsing Home</u> 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 27, Manner of Dath 28c. Injury at 28d. Sescribe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 1/Q Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

√∼ State Registrar

DHMH 17 Rev 7/2009

N. Rollin

ss of person who completed cause of death (Item 23a) (Type, Print)

2010

21278

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08:35AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, T 4c. County of Death Memoria timore If Unde 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Director or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Kes 2 No ĦMOV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ò 1 Yes No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifet DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ည 19a. Informant's Name/Relationship (Type, Prir eet and Number or Rural Route Number, 19b. Mailing Address rion 0a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. 1 Seurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Myocardia Pnysician disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o hth, Day, Year) 30. Name and address of person who completed use of death (Item 23a) (Type, Print) arkwa) niver

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Regis

ar's Signature

			For State Registrar	State of I	Maryland / L		rtment of H ificate of D		ina ivie	, ,	iene eg. No. 2	010	18750				
	Physicia Medi		1. Decedent's Name (First, Mic	. ,						Date of Deat	n Pay	2010	3. Time of Death <b>11:28 A</b> M				
	Exami		4a. Facility Name (if not institut		4b. City, Town, or Location of Death  TOWSON					4c. County of Death <b>BALTIMORE</b>							
	Funeral Director	Г	5. Social Security Number 213-36-6813	6. Sex 7 1 ■ M 2 □ F	Age (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		. Date of Birth (Month, Day 1 <b>–06–1</b> 9	41	9. Birthp Count	lace (State or Foreign ry) MD				
	yland -f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. Cour  MD Ba	ALTIMORE	10c. City, Town							10	Od. Inside City Limits				
	ith the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number				10f. Zip Code				J	of What Coun					
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status  1 Never Married 2 And 3 Widowed 4 Divord 15. Dece (Specify only high	lf Yes, Give Year or Dates dent's Education phest grade completed)	nt Ever in U.S. s? \(\sigma\) No 3.	Decede	as Decedent of His Yes, specify Cuban Yes 2 No Not use 1 No No No No No No No No No No No No No	panic Origi , Mexican, Specify:			Spe	Race - America Black, White, e ecify: BLA of Business Ind	CK				
d 212	filed within al Hygiene. d other tha	Be Cor	Elementary/Seconday (0-12  12  17. Father's Name (First, Middle		or 5+)		ERAL SER		r'a Nama /E	First, Middle, N		GOVER	NMENT				
Maryland	uld be file Mental I narked o natic eve	일	HOWARD ALEXAL	,				MOZE	TTA	EWIS							
	and 2 should Health and Me tem 27 is mar ther traumati		19a. Informant's Name/Relation  MARGARET JONI		19b. <b>2</b> !	Mailing <b>512</b>	Address (Street ar 1/2 SYCA	nd Number MORE	or Rural R	oute Number, BALT]			ode) <b>1219</b>				
Baltimore,	m		20a. Method of Disposition  1 XBurial 2 Cremati 4 Donation 5 Othe		-	y, crema	tion (Name of atory or other place FOREST C		Dat <b>6-17-</b>			ion - City or To	wn, State  S. MARYLAN				
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service	e Licensee	rton		Name and Address						F.H., INC.				
	Physician/ Medical Examiner		23a. Pa. 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	at only one cause on each	sed the death. Do no line. State as a consequence of	ot enter		such as ca				(	Approximate Interval Between Onset and Death				
Box 68760 %	The law requires tha ate has been signed page 2 should be de	ıysician/Medical Examiner	/Medical	ledical	dical Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate Experience of the Cause (Disease or linjury that initiated events resulting in death) Last	C	as a consequence of								
					IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown		th 2 Fetal death at at time of death		Ectopic pregnancy Other (spec <i>ify</i> )				23d	. Date of delive Month	ry Day Year		
		Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in								23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3  Probably 4  Unknow							
Recor		Completed							_	24a. Was ar autops perforr 1  Yes	y .	4b. Were autop prior to con death? 1 🔲 Yes	sy findings available npletion of cause of				
Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medic examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	eatient 2 🗆 ER/Out	patient	Other	e of Death			nce 6	Other (Specify)	Hospice				
Division of Vital Records,	Attending or death. ector: After by the fune	Certificate:	3 Suicide 6 Cou	stigation Ild not be		jury		at es 2 🗆 N	No	Describe ho     Location (Str     City or Town	reet and Nu	curred imber or Rural i	Route Number,				
ō	lospital or 4 hours afte uneral Dir ed filled in	Medical C		ng Physician: To the best													
	To the Hospital within 24 hours To the Funeral completed filled	Me		ng Nurse Practioner: To t				time, date a number	and place, a	and due to the	cause(s) and		ted.				
J	10X1		30. Name and address of person	who completed cause of	f death (Item 23a) (Ty	ype, Pri				AITIMA	OF A	10 21	204				

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) **JUN 1 6 2010** 

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea Day 15 Month Year 2:32A Simaki 2010 une 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 XM 2 □ F 42 162-64-0405 7-9-1967 Greece Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2x No Greece Piraeus Athens 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number 18535 162 Ipsilandou St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 2 **M**No 1 ☐ Yes 2 XNo Specify: Specify:White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Psychology Psychologist 5+18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Kalellis Electra Gaitanarou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\overline{
m DC}$ 19a. Informant's Name/Relationship (Type. Print) 20009 Washington, 1308 Clifton St., NW, Pat Kalellis - Brother 1F, #207, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-26-10 | Piraeus, Greece Anastasis Cemetery 22. Name and Address of Facility Bradley-Ashton Funeral of Funeral Seprice Li 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) acute lymphoblastic loukemia

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

is marked other than

Lepartment of Heath at Important: If item 27 is any injury or other traumonce.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical Completed by Be မ Certification:

Division of Vital Records, P.O. Box 68760,

Examiner	Se ientially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
dical	L.	d					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic preg her (speci			23d. Date of de Month	livery Day Year
þ	Part II. Other significant conditions co	ontributing to death but not resulting in the unde	rlying cau	use given in Part I.	23e. Did to	obacco use contribute t res 2 TNo 3 P	o the cause of death? robably 4 🗌 Unknown
Completed		· · · · · · · · · · · · · · · · · · ·			24a. Was a autop: perfor 1 \( \text{ Yes} \)	sy prior to death?	utopsy findings available completion of cause of s 2 \(\sum \text{No}\)
-	25. Was case referred to medical		-	26. Place of Deat	h (Check only or	ne)	
To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 I ER/Outpatient 3	3 🗌 DOA	Other: 4 Nursing Ho	me 5 🗌 Resid	ence 6 - Other (Spe	cify)
ation: T	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	now injury occurred	
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, o	ffice	28f. Location (S City or Town	Street and Number or F n, State)	lural Route Number,
Medical C	29a. Certifier (check only one)	ysician: To the best of my knowledge, death oc niner: On the basis of examination and/or invest and manner stated.	curred at igation, in	the time, date and place, n my opinion, death occu	and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. ue to the cause(s)
Me	29b. Signature and title of certifier	2 ,	29c. L	icense number		29d. Date signed (Mon	th, Day, Year)

RES- 600

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Da Year)

Timo

29b. Signature and title of certifier

Harris 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

DHMH 17 Rev 1/2001

after death. Director: Aft the

within 24 hours after de To the Funeral Director completely filled in by the the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town or Location of Death 4c. County of Death Examiner Seasons Hospice/Northwest Hospital Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1XXM 2 □ I **Funeral** Days Hours Country) 1922 Maryland Director 214-16-9317 88 Jan. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must ha matified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xxXNo Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4802 Ruby Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Musician/Retailer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Emory Ernest Knode Rosa Dora Brunier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4802 Ruby Avenue, Halethorpe MD 21227 Audrey Knode-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery June 11,2010 4 Donation 5 Other (Specify) Baltimore Maryland 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signature of Funeral Service Licens 1328 Sulphur Spring Road Arbutus MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Between Orset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death
Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 1 🗌 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month Day 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number Date signed (Month, Dav. Year)

Registrar

DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year)

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 06 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of De BURNIE 4NNE ARUN BWMC 24 Hrs. 8. Date of Birth (Month, Day, . Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Hours Director 215.12.9912 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examinar must be notified at Director 1 □Yes 2 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 HOLLINS FERRY RD. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XX No ģ Specify: Specify. 3 → Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** 12 LISKEY ALUMINUM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM OLSEN CATHERINE FINN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5963 LOWTON AVE ROCK HALL, MD 21661 DONNA OLSEN MERCER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any Injury or ot Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLEN HAVEN CEMETERY 6.12.2010 GLEN BURNIE, MD 21. Signature of Funeral Service Lice K. GREGORY FINK 22. Name and Address of Facility FINK FUNERAL HOME, P.A. M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a, Part 1 Enter the disease, heart fullure mp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y on cause on each line. Approximate Interval Between Onset and Death shock Immediate Ca e (Fin disease or condi-resulting in death) **Physician** HRS 4 CUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any last line content cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 II No 1 □ Yes 1 ☐Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical P Certifying rifysician: to the best of my amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

SAMUEZ

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

CON

10-04511 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eytan Kaplowitz State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day June 14, 2010 Medical Examiner 1545 hrs KAPLOWITZ 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3109 North Brook Road Pikesville Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 643-03-8552 Country) 1 X M 2 F 23 08/16/1986 Yrs NJ Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. BALTIMORE BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3109 NORTHBROOK ROAD 21208 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married 1 Yes it: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner my ltimore, MD 21215-0036 it. Pages 1 and 2 should be filed within 72 hours after or rement of Health and Mental Hygiene. If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify. WHITE à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ GARY KAPLOWITZ CAELA Michaela ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <del>21209</del> 21208 DR. GARY KAPLOWITZ/FATHER 3109 NORTHBROOK ROAD, BALTIMORE, MD 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, de maidre out of Disce) ANSHE 1 X Burial 2 Cremation 3 Removal from State VESHEAR CEMETERY 6/15/2010 Donation 5 Other Specify 21. Signature of Funeral Service Licens 22. Name and Address of Facility Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last physician and the burial - trans Physician/Medical UNPENDED 20c, per Fh g904 6/16/10 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth attending or use as t 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown this certificate has been signed by the sal director, page 2 should be detached for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 歹 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other; Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 V Yes 2 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury After 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: FOUND Subject shot self 1 Natural death. 1 Yes 2 ✓ No Director: Pending 1538 hrs Jun 14, 2010 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be determined (Specify) Single Family Home 3109 North Brook Road, Pikesville, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 15, 2010 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

DOME

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryla State of Maryla Registrar		artment of He <i>tificate of De</i>		ental Hy	giene Reg. No.	010	18755
6	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of Death
N. Carlot	/Medic	cal	MARLUS  4a. Facility Name (If not institution, give street and number)		7 L C 4b. City, Town, or Lo	ocation of Death	JUNE		2010 County of Deat	
	Examir	ier	The Johns Hopkins Hospital		Baltimore C			10.0	Journal of Deal	,
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birt	thplace (State or Foreign untry)
ŀ,	Director		220-11-3423 Usual Residence of Decedent	23 Yrs.			July 7	,1986	5	Maryland
	aryland show d at		10a. State 10b. County 10c.	City, Town or Lo						10d. Inside City Limits
	e Mar 8a-f s	Director	MD N/A Ba	altimore	<b>:</b>					1 XYes 2 No
	with the	D.	10e. Street and Number 202 South Augusta-Avenue		10f. Zip-Code 21229				en of What Co	untry?
	death with the Maryland ms 23a or 28a-f show must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in	U.S. 13.1	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No	- US	5A 4. Race - Ame	rican Indian,
12-0036	be filed within 72 hours after death with the Mai Ital Hygiene. ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified	by	1 1  Never Married 2  Married			Mexican, Puerto F Specify:	Rican, etc.)		Black, White Specify:	e, etc. Black
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מ פ	e filed value other to	Be C	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	(First, Middle	, Maiden S	Surname)	
yland		임	Kevin Lamont Faison			ionette E	_		-	
Jan	2 sho and is ma rauma	1 7	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street and					
e O	iges 1 and 2 should to f Heatth and Mer If item 27 is marks or other traumatic		Debra Rice Little-grandmother  20a. Method of Disposition 20		South Augus		ie Balt		ation - City or	
Ď	Pages nent of h	/	1 Burial 2 Cremation 3 Removal from State		esition (Name of matory or other place)  To Cemetery		2,2010		ltimore	
baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signal Lie of Funeral Ser Licensee		2. Name and Address					
מ	중국 등 등 원		Car und Harris		28 Sulphur				ıs MD 2	
			23a Part 1. Enter the disease, or complications that caused the of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		er the mode of dying,	such as cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
,	Physician /Medical	i	disease or condition resulting in death)  a. Due to (or as a cons	equence of):						
	Examiner		Sequentially list conditions, b						33	
	sit ed	Examiner	if any, leading to immediate Due to (or as a cons	equence of):						
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200	ath ce ttendir for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Frequant at time of	etal death 3	Ectopic pregnancy			23	d. Date of del Month	livery Day Year
5	the de / the a ached	hysi	1   Yes 2   No 9   Unknown 9   Unknown	Tueaur 5	Other (specify)					
cords, r.	v requires that the death certifue signed by the attending should be detached for use a	by	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given	in Part I.	23e. Did to			o the cause of death?
חבבח	= 00 N	Completed							24b. Were au prior to death?	ntopsy findings available completion of cause of
g	ian: T	Be C	25. Was case referred to medical examiner?		26	6. Place of Death	1 \( \text{Yes} \) (Check only or		i	2 No
5	hysici his cer al dire	은	1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient		4 Nursing Hom				ify)
5	Jing P h. After t funera	ij	27. Manner of Death  1 Natural  2 Natural  2 Natural  2 Natural  2 Natural  2 Natural  3 Natural  3 Natural  4 North, Day Year)  1 Natural  1 Natural  1 Natural  1 Natural  1 Natural  1 Natural	28b. Time of Injury	Work?	2 No	8d. Describe h	now injury	occurred	
2	Attenorate death	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, stre					Number or Ru	ural Route Number,
5	Ital or Irs afte all Dir.	Sel					City or Tow	,		
	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page:	edical	29a. Certifier (check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinent and manner stated.	nowledge, death nation and/or inv	occurred at the time, restigation, in my opini	date and place, a ion, death occurre	nd due to the ed at the time,	date and p	and manner as place, and due	stated. to the cause(s)
	To the corr	Σ	29b. Signature and title of certifier		29c. License nu	_		29d. Date :	signed (Month	1
•		-	30. Name and address of parson who completed equal of the tri	tom 20a) /Fire		1419/		JUNI	. 1	610
	3		30. Name and address of person who completed cause of death (I		conty	600 N	orth Wo	lfe St,	Baltimo	ore, MD, 21287
	Sta Registra	~	31. Date filed (Month, Day, Year)  JUN 16 2010  32. Registrar's Sig	Parks						
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DHMH 17 Rev 1/2001

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Harry Lamont Lo	ond		Stat	te of Marylan	d / Depa	artment	of Hea	alth and	l Mental F	Hygier	ne	201	0 1075
		1- For State Registrar			Cei	rtificate	of Dea	ath			Reg. N	4 U I	0 1013
Physici	an/	Decedent's	Name (First, Middle,I	ast) Harry L	amont	Lundy	, Jr.	•			e of Death		3. Time of Death
Medical Exami	ner	Hos	alla	nont	lon	de	To	_		Mon Jun	e 12, 2010	y Year D	2123 hrs
		4a. Facility Na		give street and numb	er)	<u> </u>	4b. City	, Town, or L	ocation of Dea			4c. County of De	eath
		Anne Ar	undel Medical C	enter			Ann	napolis				Anne Aruno	lel
Funeral		5. Social Secu	rity Number 6.	Sex 7.	Age (In yrs. I	ast birthday)	lf Ur	nder 1 Year	If Under 24H	rs. 8. Da	ate of Birth (M		Birthplace (State or
Director		410 00	3-3865	<b>X</b> M 2 F	2	5	Yrs. Mor	nths Days	Hours Mi	in. 1/	7-111		reign Country) 11
		Lisual Residen	ce of Decedent	<b>✓</b> " -□'	<u></u>	<u> </u>	110.		LL.		7 17-	170 T	
any		10a. State	10b. County			Town or Lo					<u>-</u>		10d. Inside City Limits
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rylan a-f sl	cto	10e. Street and				<u> </u>	10f. Z	Zip Code	10		10a C	itizen of What C	
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ith th 23a notif	<u>=</u>	6	inger	view C	r· A	<b>₩</b>				<u>ر</u>	ļ	431	7
tth wi	Funeral I	11. Marital Star 1 Never M		12. Was Decede	s?				anic Origin? ( § Mexican, Puert			14. Race - An White, etc	nerican Indian, Black, c.
or in	Fu			1 Yes	2 No		¬					7	RIACK
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d off		17. Father's Na	ame (First, Middle, La		)			19	3.Molher's Nam	ne (First, i	vilodie, Maide	on Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a Informanti	s Name/Relationship	(Turn Brot)		10h Mai	lina Addro	Ctroat	Ira	<u>. Co</u>	YK	City or Town, St	ata Zia Cada)
Shoul shoul	ř	Too	s Name Relations in		1.0)	190. IVIAI		ss (Sireera	and Number of	Rurai Ro	ute Number,	City or Town, St	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of	Disposition	5 (1904) 25	her)	Place of Dier	osition (N	ame of ceme	etery L	Date	<u>و, پر</u>	Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite			2 Cremation	3 Removal from	State	rematory or	other plac		6	119/2	-	. Location - Oity	or rown, state
Page Page nent ant:		4 Donatio	n 5 Other Spec	ify:	Du	yan	ey V	alley	CARTE	4	I	30Jtin	LONE, MD
alt rmit. sparti		21. Signature o	of Funeral Sorvice Lic	engee		· F	me ar	nd Address o	of Fecilingo	Lie	ture	eral Se	ries
<b>m</b> 80 a a		Z-M	1.	<u></u>	<		400	15 K	OFER	$\mathcal{A}$ :	Bal	10.MI	21212
Physician	-		er the disease, or co st only one cause on	mplications that cause each line.	ed the death.	Do not ente	r the mode	e of dyirig, su	uch as cardiac	or respira	tory arrest, s	hock, or heart	Approximate Interval Between Onset and
/Medical Examiner				a. Traumatic Ca	rdiac Rup	ture							Death
LAMINITE		or condition re	sulting in death)	Due to (or as a cor	nsequence of	F):							
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	Examiner	if any, leading cause. Enter U	to immediate Jnderlying Cause	Due to (or as a cor	nsequence of	·):							
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187 Tiffice ing p	2		dent pregnant in the	1 Live birth	-		Fetal deat	h 3	Ectopic pregn	nancy	- 1	Month	Day Year
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etach by	by P	Part II. Other s	ignificant condition	s contributing to dea	ath but not re	sulting in the	e underlyir	ng cause give	en in Part I.	236			to the cause of death?
sign of 1 be d										. 1	Yes 2	<b>√</b> No 3 P	robably 4 Unknown
rds requ	Completed									248	a. Was an autopsy		autopsy findings available o completion of cause of
e law e has	티									·	performed	death	?
: Th		25 Mon 2002 F	eferred to medical	_				26 Diana et	Coath (Charle		Yes 2	No 1 🗸	Yes 2 No
Division of Vital Records, P.O. real or attending Physician: The law requires that the start death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	8	examiner?		Hospital:	tient 2	EB/Outpotio	nt 2		f Death (Check ther Nursi	ing Home		4 6 0	her.
Phys er thi	٩	1 ✓ Yes 27. Manner of [	2 No	28a. Date of Ir		28b. Time o		28c. Injury				dence 6 Oth	ner.
ding Aft	on:	1 Natural		EO(Month, Day	(,Year)	FOUND:	i injury		s 2 V No			playing foot	tball
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lor / after Dire	ij	3 Suicide					reet, factor	ry, office buil	lding, etc.	or T	Town, State)		Rural Route Number, City
Spita spita nours neral	Certification:	4 Homicio	de determir	(Specify) S	port/Athle	tic				1265 G	reen Holly I	Drive, Annapol	lis, MD
e Ho n 24 l e Fu		29a. Certifier (Check only one)	=	ician: To the best of									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical	2		er: On the basis of ex and manner states		id/or investig				at the time	e, date and p	lace, and due to	the cause(s)
	Σ	29b/Signature	and title of certifier				29	9c. License r			29d	. Date signed (A	Month, Day, Year)
		( ) L	Turberl	earl				O.C.M.	.E.	2.	Ju	ne 13, 2010	
	1	30. Name and a	address of person wh	o completed cause of	death (Item	23a)							
		Laron Lo	cke MD. Assi	stant Medical Ex	xaminer	111 Per	n Stree	et, Baltimo	ore, MD 212	201			
St	ate	31. Date filed (A	Month, Day Year)	C 00 22. Regist	ar's Signatur	e A	han	Kel					
Regist			. II IN I	n /IIIII //	VALLOWN!	100	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23aPtI,II,25 per main 308 of 19/23/2010dhb

Red, No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year James C. Martin 11:31 11, JUNE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT BALTIMORE AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/27/1959 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Sex ¥EXM 2□ F Months 51 Davs Hours Min. Director MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show event, the Medical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yes 2√√No Director 10e. Street and Number 5641 Calyn Road, Apt C 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or item any injury or other traumatic event, the Medical Evandor and ben once. 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Army KMYes, specify Cub. KMYes, Give Nat. Guard 1 □Yes 2 MXo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify. Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Auto Body Worker Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald A. Martin Ilena G. Frev မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria L. Blackburn /Sister 6068 Old Hanover Road, Spring Grove, PA 17362 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date Linthicum Chapel Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/2010 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Charles T. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Obstructive Pulmonary Disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications of Physician CARDINE AFREST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) The law requires that the death certificate be execute Exami burial-tran Due to (or as a consequence of) MARTIN, JAMES C. Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 🗌 Unknown þ Aner this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner?

12 Yes 22 No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the moor after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar AVE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHION

00

31. Date filed (Month, Day,

JUN 1 6 2010

JUNE 11, 2010

BALTIMORE MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	/larylan		rtment tificate			and M	-	giene Reg. No	211111	18	758
	Dhusisia	/	1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath Da	y Year	3. Time	e of Death
	Physicia Medic	al	Woodrow W. Mo								June 1	3,20	10	10:3	36P M
4	Examin	er	4a. Facility Name (if not institution, g	,			4b. City, To		ocation o	of Death		4c.	. County of Deat Balto.	h	
			Gilchrist Cent  5. Social Security Number		an din um d	ont hirth day)	If Under 1	son	If Under	24 Hre	0 D-1/ B'-			h l /04	
	Funeral Director		217-48-9164	1 XM 2 □ F	60	as <i>t birthd</i> ay) Yrs.		Days	Hours	Min.	8. Date of Bird (Month, Da June 2	rn y, Yea <i>r</i> ) <b>9 , 1</b> 9	49 Mar	nplace (Sta untry) y land	te o <i>r Foreig</i> n
	T MO		Usual Residence of Decedent  10a. State 10b. County		1.0.00						22/2/17/11/1				
	rylan I-f sh ied a	[호			10c. Cit	y, Town or Loc									e City Limits
	r 28a notif		Md. Balt  10e. Street and Number	0.		Parkvi	10f. Zip C	'ada				10 0"			Yes 2 XNo
	/ith th	Funeral Director							٠,			10g. Cit	tizen of What Co	untry r	
	ems r mu	, e	8117 Bon Air R	12. Was Deceden	t Ever in U.S		as Deceder	2123	panic Orio	gin? (Spe	cify Yes or No-	T	USA 14. Race - Amer	rican Indian	-
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces d 1 Yes 2 If Yes, Give Year or Dates.	X No	If	Yes, specify	Cuban	, Mexican	, Puèrto I	Rićan, etc.)	- 1	Black, White	e. etc.	,
2-0	hour natu dical	Sete	15. Decedent'			16a. Decede	ent's Usual (	Occupat	ion			16b. K	ind of Business	Industry	
2	in 72 ie. han "	Completed	Elementary/Seconday (0-12)	College (1-4 or	r 5+)	Ìife. DC	nd of work of NOT use re	etired)	nng most	or workii	ng			•	
21	d with ygien her ti	اما	12th			Land	lscape	T					ndscapi	ng Con	npany
and	e filed ntal H ed ot ever	P B	17. Father's Name (First, Middle, Las								(First, Middle,		Surname)		
Ĕ	ould b d Mei mark matic		Woodrow W. Mo  19a. Informant's Name/Relationship			T					Newhai				
Ma	2 sho th an 27 is trau	Ш	Barbara A. Mon			1	Bon A						Town, State, Zip		
ē,	I and I Hea		20a. Method of Disposition	ks Spo	20b. F	Place of Dispos	ition (Name	of			ate		ocation - City or		
JO L	age Tent of nt: If i		1 🕅 Burial 2 🗆 Cremation 3 4 🗀 Donation 5 🗆 Other (Sp.			emetery, cremi aney Va		er place)			-2010		onium, 1		
alti	mit. F partm sortal / injui		21. Signature of Funeral Service Lic		рил	<del></del>	Name and	Address			1		neral H		
Ä	an I De		Buen G. 1	علالعلنا	~		9705	Be1a	air F				, Md. 2		
1	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Itany, and	a. Due to for an	ne.  Olyginal Salconseques a conseque	SUAS uence of):						est,		Approxir Interval Onset a	mate Between nd Death
Box 68760	cate be e physicial the buri	/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \text{Unknown} \)	Due to (or as  23c. If yes, outcom  1	e of pregna 2 ☐ Feta at time of c	ncy	Ectopic pre	gnancy					23d. Date of del Month	ivery Day	Year
0	at the	P.	Part II. Other significant condition	s contributing to death	but not res	ulting in the un	derlying cau	use give	n in Part I		23e. Did to	obacco u	se contribute to	the cause o	of death?
S, F	ires that signed I d be det	d b	VASCULITIS								1 🔯	Yes 2	□ No 3 □ Pr	obably 4	Unknown
ord	requires been sig should b	lete									24a, Was	an	24b. Were aut	opsy finding	gs available
ec	The law ate has page 2:	티		·							autop perfo	rmed?	death?	completion of	of cause of
al F	iclan: The certificate rector, pag	Be C	25. Was case referred to medical					26. Plac	e of Deat	h <i>(Check</i>	1 \(\superstack Yes\)	2 A No	o∐ 1 ∐ Yes	2 🗆 No	
<u> </u>	ysiclan: is certific director,	10 B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	tient 2 🗆	ER/Outpatient	3 ☐ DOA	Other:	4 🗆 Nu	rsing Hor	ne 5 🗆 Resid	lence 6	XOther (Speci	to Has	PILE
of	ding Phys h. After this funeral di	ë	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of in (Month, D	ury ay, Year)	28b. Time of injury	28c	. Injury a work?			8d. Describe h				
ion	ttendii death. stor: Ai / the fu	itica	2 Accident Investiga 3 Suicide 6 Could no	tion			M	1 🗆 Ye	es 2 🗌	No					
Division of Vital Records, P.O.	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the	al Certificate:	4 Homicide determin	28e. Place of Ir	ijury - At ho tc. <i>(Specify,</i>		et, factory, o	ffice		2	28f. Location (S City or Tow		d Number or Rur	al Route Nu	ımber,
	Hosp 24 hou Funel sted fil	Medical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of	examination	and/or investig	gation, in my	opinion,	, death oc	curred at	the time, date a	nd place,	, and due to the o	ause(s) and	manner stated.
	To the within 2 To the comple		only one) 3 L Certifying N  29b. Signature and title of certifier	urse Practioner: To th	e best of my	/ knowledge, de		d at the t		and place		<del></del>	e) and manner as a te signed (Month		
	F S F Ö			150/	1)	, _				-					
	4		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type Pri	int)	VIC	11			vn	7171	010	
	0		30. Name and address of person with OAN/IEUE OUSE.	RMAN MD	670	V N CH	ARLES	S7.	· 8U	118 4	4105 4	BALT	MITEIR	10 2	1204
	Stat Registra		31. Date filed (Month, Day, Year)	2010 32. Revist	rar's Signat	ure d. 4	back	1		-					-

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Robert Liewelly	II IVIC	1- For State Certificate of Registrar		Reg. No. 201	1875
Physici Medical Exam			2. Date of Month June		3. Time of Death 0850 hrs
		4a. Facility Name (if not institution, give street and number) 4015 24th Place	4b. City, Town, or Location of Death Temple Hills	4c. County of Deat	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs. B. Date	of Birth (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		212-04-9267   X M 2 F 39 Yr	s. Months Days Hours Min. 3-	13-1971	grWash DC puntry) USA
v any		Usual Residence of Decedent  10a. State	e Hills		10d. Inside City Limits
Aaryland 28a-f show 1 at once,	ctor		10f. Zip Code	10g. Citizen of What Cou	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Directo		20748	United St	
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. 13. W Armed Forces? 1 X Yes 2 No	as Decedent of Hispanic Origin? ( Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, et		rican Indian, Black,
s after d ral", or	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	* *		lack
) 72 hour n "natu al Exan	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nt's Usual Occupation (Give kind of work done nost of working life, DO NOT use retired)	16b, Kind of Business.	rindustry
-003( J within giene. ther tha	Completed	1 2 Commi	unication    18.Mother's Name (First, Mi	Private	
21215-0( Id be filed win Mental Hygier narked other event, the M	Be	Robert R. McDowell	Euthina S.	McDowell-Do	
	2	19a. Informant's Name/Relationship (Type, Print)  Euthina S. McDowell-Dorsey 4326	ng Address (Street and Number or Rural Rout 23rd Place Temle		
tri fea an			sition (Name of cemetery, Date	20c. Location - City of 10 Elizabeth	Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		1 4 Donation 5 Other Specify:	Name and Address of Facility A. Sande		
		23a. Palt I. Enter the disease, or complications that caused the death. Do not enter	3329 Woodbridge St	•	Je.VA 2219
Physician /Medical Examiner	4	failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic (heroin) in		ory arrest, shook, or rear	Between Onset and Death
ZXaIIIIIei		or condition resulting in death)  Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate  Cause Enter Underlying Cause  C.  C.			
ted 1 Insit	Examiner	events resulting in death) Last  Due to (or as a consequence of):			
68760, certificate be executed nding physician and ise as the burial - transit	dical	d.    X UNPENDED   AMENDED   23a,27,28a-f,per     F FEMALE:   23c.   If yes, outcome of pregnancy	ME g904 6/21/10 TT		
18760, rificate be ing physici as the buri	an/Me		etal death 3 Ectopic pregnancy	23d. Date of deliver Month	y Day Year
P.O. Box 6876 so that the death certificate gned by the attending phy e detached for use as the	Physician/		ther (Specify)	_	
b.O. Ithat the ned by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to	==
ords, P.C. w requires that as been signed by should be detailed.	ompleted			Was an 24b. Were a	utopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sed in by the funeral director, page 2 should the company of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	dmo			autopsy prior to performed? death?  Yes 2 No 1 ✓ Y	
fital Rec sician: The is certificate lirector, page	Bec	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check only one) t 3 DOA Other4 Nursing Home	5 Residence 6 🗸 Othe	r: Scene
n of Vital Ling Physician: After this certifi	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of	Injury 28c. Injury at Work? 28d. Des	cribe how injury occurred	
/isior r Attenc ter death irector: n by the	Certification:	2 Accident Investigation Fd 6/5/10 Fd 8:3	8 am 1 Yes 2 No unk et, factory, office building, etc. 28f. Loca	ition (Street and Number or Ri	ural Route Number, City
Divisi ospital or At hours after d ineral Direct y filled in by	Certi	4 Homicide determined (Specify) residence		tion (Street and Number or Ri own, State)4015 24th Le Hills, MD	· · · · · · · · · · · · · · · · · · ·
Division of Vital Records, P.O. Box within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	Certifying Physician: To the best of my knowledge, death occur one)  2 Medical Examiner: On the basis of examination and/or investiga and manner stated.	red at the time, date and place, and due to the tion, in my opinion, death occurred at the time,	e cause(s) and manner as stat , date and place, and due to the	ed. ne cause(s)
F \$ F 8	Ĕ	29b. Signature and title of certifier	29c. License number O.C.M.E. OCME	29d. Date signed (Mo	nth, Day, Year)
1	}	30. Name and address of person who completed caused death (Item 23a)	, John C. John C.	23110 0, 2010	
1		Theodore M. King, Jr., MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Baltimore, MD 2	1201	
St Regist			barker		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G907, 9/14/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 ear JUNE 12 KEVIN MATHEW MULLEN 9:38 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, ) Country) MARYLAND Days 1 X M 2 - F Months Hours Min. Year Director 19 219-31-8325 Usual Residence of Decedent or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No MARYLAND MONTGOMERY GAITHERSBURG 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral within 72 hours after death with 7308 CLIFF PINE DRIVE UNITED STATES 20879 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Completed 3 Divorced 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within the Health and Mental Hygiens item 27 is marked other the STUDENT COLLEGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam မ Shimulunas JOHN FRANKLIN MULLEN LAURA JAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Healt Important: If item 2 any in ury or other t JOHN & LAURA MULLEN/ PARENTS CLIFF PINE DRIVE, GAITHERSBURG, MARYLAND 20b. Place of Disposition (Name of GATE terry, crematory or other place)
OF HEAVEN CEMETERS 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 $^{-1}$ Burial 2 $^{-1}$ Cremation 3 $^{-1}$ Removal from State JUNE 4 Donation 5 Other (Specify) HEAVEN CEMETERY 2010 SILVER SPRING, MARYLAND 22. Name and Address of Facility ROBERT ROCKVILLE, INC. 300 V r A. PUMPHREY FUNERAL HOME/ WEST MONTGOMERY AVENUE 20850-2805 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the dis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final TWO WEEKS Physician/ PNEUMOCYSTIS JIROVECI PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HODGKIN LYMPHOMA SEVEN YEARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has but irector, page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA ပ 1 Yes 2 💢 No 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide Investigation by the 1 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in 24 hours a Funeral D Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🛮 only one) Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe D0069053 JUNE 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 AMY PARKER RUHI 10 CENTER DRIVE, BETHESDA. MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State au IUN 162010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 11, 2010 Alice Faye Mason 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 143 Olen Drive Anne Arundel Glen Burnie Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🗆 M 2 💢 F 1/14/1940 Director 70 219-38-6795 iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143 Olen Drive 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify "natural", 3 🕅 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ernest J. Childres Iva Lee Melton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic \_\_\_\_ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Billiat / Daughter 143 Olen Drive, Glen Burnie, Maryland 21061 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2010 Bayview Crematory Baltimore, Maryland ignature of Funeral Service Lice 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final set and Death Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2: performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Regist ar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **MONTH**NE MARGARET ROSINA NOVASECKO $1^{\text{Day}}$ 2010 9:35P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Hours Min. April Day Year918 <sub>Country)</sub> Marvland 92 **Director** 220-07-2824 Usual Residence of Decedent 28a-f shov 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Baldwin Maryland Baltimore 1 Yes 2XXNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21013 5601 Patterson Rd. USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. other traumatic event, the Medical Examiner Black, White, etc. P þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 filed within 72 hours after Specify: White 1 Yes 2 No Specify. 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Ben Franklin Salesperson N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Margaret Anna Endres Joseph Peter Diepold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria M. Rosellini (Daughter) 5601 Patterson Rd. Baldwin, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 $\blacksquare$ Burial 2 $\square$ Cremation 3 $\square$ Removal from State Russian Orthadox Cem. 9 6~16~10 Baltimore, Md. injury 4 Donation 5 Other (Specify) Andrews ure of Funeral Service Licenses Lassann Funeral Home Belair Rd. Baltimore. md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ METASTATIC CANCER PRIMARY UNKNOWN disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to jor as a consequence of: cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 7 9 Unknown 2 X No To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ☐ Yes 2 🗶 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar

24 hours

Medical

29a. Certifier

(Check

only one

JACKIE JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

CNRP

NOVASECKO

MARGARET

2300 DULANEY VALLEY RD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM, MD 21093

29d. Date signed Month. Day, Year

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Sandra Lee Nazelrod June 11 8:30  $A^M$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13616 Turnmore Road Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 218-58-1506 1 □ M 2 🖾 F August 2, 1951 Washington, D.C Yrs. **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 13616 Turnmore Road 20906 United States ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Benjamin Alvey Elizabeth Jane Hilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Nazelrod/Husband 13616 Tunmore Road, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Dale8. Page 1 Gacemetery, crematory or other Gacemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service Licenses M01498 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Sclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: sate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No Yes 2 🔀 No 1 Yes Division of Vital Hospital or Attending Physician: Be ( funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Hospital 2 🛛 No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the only one 29b. Signature and title of cert 29c, License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

M.D.

Nakul Goyal, 31. Date filed (Month, Day, Year, D38457

3801 International Drive, Silver Spring, Maryland 20906

June 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10: 35 AM CLARA JUNE 2010 OTOOLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year
APR. 6. 1 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months 218-07-5447 92 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD. BALTIMORE EASTWOOD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7011 GOUGH ST. 21224 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates other than "natu 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8TH 0 HOMEMAKER OWN HOME t. Page 1 and 2 should be filed wit tment of Health and Mental Hygie tant: If item 27 is marked other ijury or other traumatic event, tt Be 18. Mother's Name *(First, Middle, Maiden Sumame)* SOPHIE DELINSKA 17. Father's Name (First, Middle, Last, JOSEPH BETLEJESKI ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT O'TOOLE/SON 1109 WILD ORCHID DR., FALLSTON, MARYLAND 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) 6/15/2010 BALTIMORE, MARYLAND OAK LAWN CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21224 BALTIMORE, MARYLAND 6224 EASTERN AVE., 23a. Part 1. Enter the disease implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
10 HIN shock, or heart failure. Lie only one cause on each line Immediate Cause (Fi Physician/ PULSELESS ELECTRICAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SHOCK CARDIO GENIC 1 DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): 1 YEAR Hospital or Attending Physician: The law requires that the death certificate be executed SEVERE ADRTIC STENOSIS and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar LORA

BANICOVA,MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN

RES-000

AVENUE BALTIMORE, MD

JUNE 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Month June 8:45 P M Loida Pendas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Manor Care-Potomac Montgomery Potomac Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) February 6, If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1 M 2 X F Hours 91 Country) **Cub**a **Director** 085-07-5304 1919 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ser must be notified Maryland Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10714 Potomac Tennis Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 X Yes 2 ☐ No Specify: Cuban 3 x Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maria Perez Eugenio Calejo Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Pendas Whitten/Daughter 4710 Derussey Parkway, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Tate 8, emetery, crematory or other place klawn Memorial 1 X Burial 2 Cremation 3 Removal from State Parklawn 4 ☐ Donation 5 ☐ Other (Specify) 2010 Rockville, Maryland Pumphrey Funeral Home/ 7557 Wisconsin Avenue Robert A. Signature of Funeral Service Licensee 22. Name and Address of Facility Bethesda-Chevy Chase 17c. Bethesda, Maryland 20814 M01498 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ months Failure to Thrive Medical Examiner nding physician and use as the burial-transi

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

	resulting in death)	Due to (or as a conseque	ence of):				
_	Sequentially list conditions,	Renal	Malignanc	y			years
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a conseque	ence of):				
Medical Ex	resulting in death) Last	Due to (or as a conseque	ence of):				
_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic			23d. Date of del Month	livery Day Year
ted by P	Part II. Other significant conditions co	ontributing to death but not resu	alting in the underlying	g cause given in Part I.			the cause of death?
Comple	Dementia				24a. Was an autopsy performed? 1 □ Yes 2 ☑ 1	prior to death?	topsy findings available completion of cause of
Re	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
0	1 ☐ Yes 2 █XNo	Hospital: 1 Inpatient 2 I E	ER/Outpatient 3 ☐ I	Other: 4 😾 Nursing H	lome 5  Residence	6 ☐ Other (Spec	ify)
ertificate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
ا د	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At horn building, etc. (Specify)		ory, office	28f. Location (Street a City or Town, Stat		ral Route Number,
Medical	(Check 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or investigation, in	n my opinion, death occurred	at the time, date and plac	e, and due to the	cause(s) and manner stat
	20h Signature and title of certifier		20	a License number	204 0	ata signad /8 danté	Day Veerl

D31319

June 15, 2010

State Registrar

8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814 Loreto Albiol, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Ame	end Item	26 per	of Mary <b>verb</b>	land Dep 1904 Ce	artment 716/20 rtificate	f Health <b>Iodhb</b> of Death	and M	ental Hy	giene Reg. No.	010	10755
, ×	*	₹;	1. Decedent's Name								2. Date of De Month	ath	Vear	3. Time of Death
	Physici //Medic	_	Lillian I	Russell							May	$18^{Day}$	2010	2:45 A M
	Examin		4a. Facility Name (If	not institution, gi	ve street and n	umber)			vn, or Location	of Death		4c. Cou	nty of Death	
			Emeritus	Senior	Living			Pike	sville			Ва	ltimo	ce
10,000	Funeral Director		5. Social Security No. 057-12-50		Sex 1 □ M 2 🙀 F	7. Age (In	yrs. last birthday) 89 Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	Min.	8. Date of Birl (Month, Da Nov 15,	h Y, Yea <i>r)</i> 1920	9. Birth Cou Nev	place (State or Foreign intry) York
di.	D.		Usual Residence of			1.0	07 7							
	iryiar show	_	10a. State	10b. County	1		c. City, Town or Lo							10d. Inside City Limits
	e Ma-f sa-f s	cto	MD	Howar	α		Ellicott							1 ☐ Yes 2√€ No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	al Director	10e. Street and Nun 8700 Ri	nber .dge Road	I			10f. Zip Co 2104	_			10g. Citizen USA	of What Cou	ntry?
	dea	Funeral	11. Marital Status		12. Was De	cedent Ever	in U.S. 13.	Was Deceden	of Hispanic O	rigin? (Spe	ecify Yes or No		Race - Ameri Black, White,	
Maryland 21215-0036	urs after al", or ite	þ	1 ☐ Never Marri 3 <b>∑</b> Widowed	ed 2 Married 4 Divorced		2 <b>X</b> No aive		1 □ Yes 23€			, modin, otony		ecify:whit	
9	2 ho	Completed	/Cnoo	15. Decedent's E	ducation	7)		dent's Usual O		at of worki	na	16b. Kind o	f Business/Ir	ndustry
215	hin 7	lg	Elementary/Secon			(1-4or 5+)	life.	DO NOT use r	etired)	IST OF WORK	ng .			
21	d wit gien gien grien the	οπ	12		1		mar	nager				bank	ing ir	ndustry
b	al Hy othe	Be (	17. Father's Name (	First, Middle, Las	t)				18. Moth	ner's Name	(First, Middle,	Maiden Sur	name)	
<u> a</u>	uld b Ments Irked Itic e	2	Sam Bras	intwein					Len	ıa Kar	ntrowit	z		
an	sho and l	2 3	19a. Informant's Na								al Route Numb			
Σ	and 2		Jerola	Russell	son					e; Coo	co Beac	h, Flo	rida 3	32931
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any Injury or other tra			osition Cremation 3   5 Other (Spec		n State	0b. Place of Dispo cemetery, cre	osition (Name of matory or othe	of r place)		Pate	20c. Location	on - City or T	own, State
Balti	permit. Departn Importa any Inju		21. Sign Jure of F	neral Service Lice	Wad,	bish	ror 2						Balti	more Street
95	\$	0	23a. Part 1 Enter th	ne disease, or cor	nplications that	caused the	death. Do not en	ter the mode o	f dying, such a	aryıa ıs cardiac d	nd 2120 or respiratory a	rrest,		Approximate
J.	Dhusisian	8.4	Immediate Calise (	rt failure. List onl Final	one cause on	each line.	0.	4						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	1	a. Due to	U18	nsequence of):						-	6 months
	Examiner			- 6	Duc to	7 (OI a 12 00)	nacquerioc ory.							
8		e.	Sequentially list cor	nditions, mediate	b. Due to	o (or as a co	nsequence of):							
	uted Insit	in I	Sequentially list cor if any, leading to im Cause (Disease or that initiated events	rlyling injury										
,	icate be executed physician and s the burial-transit	Examiner	resulting in death) L		Due to	o (or as a co	nsequence of):							
8760,	sicial buri	dical		•	<b>.</b> d									
89	ficate physis the	edic			- d.		*/							
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		birth 2  gnant at time	Fetal death 3	⊒Ectopic pregr ⊒ Other <i>(speci</i>				23d.	Date of delive	very Day Year
Δ.	that the ed by detain	F.	Part II. Other signif	icant conditions	contributing to	death but no	ot resulting in the u	inderlying caus	e given in Part	ı.	23e. Did t	obacco use o	contribute to	the cause of death?
Records,	w requires been sign should be	ted by									10	Yes 2□N	o 3 <b>X</b> Pro	obably 4 □Unknown
	sician: The law certificate has be irector, page 2 sh	Completed									24a. Was auto perfo 1⊡ Yes		4b. Were aut prior to co death? 1 ☐ Yes	topsy findings available ompletion of cause of
ita	ian: artification,	Be (	25. Was case reference examiner?	red to medical					26. Plac	ce of Death	(Check only o			
<u>.</u>	Physician: r this certific ral director,	To E	1 Yes 2 X	No	Hospital: 1	] Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 🗆 N	lursing Ho	me 5 Resi	dence 6X	Other (Spec	Assisted  Eify Living
0	ng Pt fer th		27. Manner of Deatl	n 5 ☐ Pending	28a. Date	e of Injury onth, Day Ye	ar) 28b. Time o	of 28c.	Injury at Work?		28d. Describe	how injury oc	curred	
<u>.</u>	Attending It death. ector: After by the fune	atic	2 Accident	investigation	n	,		М	1 ☐ Yes 2 ☐	∃No				
Division or Vital	al or Atto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	20e. Flat	ce of injury - ding, etc. <i>(S</i>	At home, farm, st pecify)	reet, factory, o	ffice		28f. Location ( City or To	Street and No wn, State)	umber or Ru	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)		hysician: To the miner: On the and ma	ne best of my basis of exa	y knowledge, dea mination and/or in	th occurred at the occurred at	he time, date a my opinion, de	and place, eath occur	and due to the red at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	<b>Го th</b> within Го th	Me	29b. Signature and	title of certifier,	1		0	29c. L	cense number			29d. Date si	gned (Month	, Day, Year)
	/ - 0		> Elm	4 Scha	len	carl		R	11835	4		6/7	1201	0
	(0		30. Name and addy		completed car	use of death	(Item 23a) (Type	Print)	Papad	lera.	MD	2112.	2	
	Sta	te	31. Date iled (Moni	th. Dav. Year)	B.	Registrar's	Signature 2	A.D	,	/				
	Registr		JU	N 1 6 201	U Sten	1694	7. A.							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Leslie Jo Rasmussen

		1- For State Registrar	Certif	icate of		id Wentai	70	eg. No. 20	0 075
Physici Medical Exam		Decedent's Name (First, Middle,Last)     Leslie Jo	Rasmussen	-	. ,		Date of Dea     Month	th Day Year	3. Time of Death 2359 hrs
* '	IIIEI	4a. Facility Name (if not institution, give s		4k	o. City, Town, o	or Location of De	June 9, 20	4c. County of	
		7147 Holabird Avenue			Dundalk			Baltimore	County
Funeral Director		5. Social Security Number 528-04-3347 6. Sex	7. Age (In yrs. last)	birthday) Yrs.	If Under 1 Ye  Months Da				9. Birthplace (State or Foreign Country)
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Locatio	n				10d. Inside City Limits
and f show	or	MD Éalti	more		Dun	dalk			1 X Yes 2 No
Maryl rr 28a-1	Director	10e. Street and Number	olabird Ave		10f. Zip Code	24.000	1	0g. Citizen of What	t Country?
with the	ral D		2. Was Decedent Ever in U.S.	13. Was	Decedent of H	21222	Specify Yes or No		USA American Indian, Black,
r death	Funeral I		Armed Forces?  1 Yes 2 No	If Yes	s, specify Cuba	an, Mexican, Pue		White,	
urs afte tural",	by	3 Widowed 4 Divorced If	r Dates:		es 2 N	o s <i>pecify:</i> ation (Give kind	of work done	Specify: 16b. Kind of Busir	ness/Industry
6 172 ho an "na ical Exi	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		t of working lif- nemaker	e. DO NOT use	retired)		
-003 d withii /giene. ther th	Somp	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Surname)	Own Home
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be		yne Rasmussen			Myrt]	le Grange	r Gertino	
sho and 7 is	٦ م		ino / Mother	1953	Villa	Park La	or Rural Route Nurr ane, Salt	Lake Cit	y, UT 84121
F 15 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		20a. Method of Disposition  1 Burial 2 Cremation 3	D 14 OL CEPT	natory or othe	on (Name of ce r place) Matory		Date 5/15/2010	20c. Location - C	ity or Town, State  Maryland
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service License			_			ľ	
		23a. Part I. Enter the disease, or complica	ations that caused the death. Do				ns Funera		7230
Physician _/Medical		failure. List only one cause on each	line. ultiple Injuries	not enter the	mode of dying	i, suci as cai dia	c or respiratory arre	est, shock, or neart	Approximate Interval Between Onset and Death
Examiner		the set of the set of	e to (or as a consequence of):						
	je.		e to (or as a consequence of):						
``	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):						
760, crate be executed physician and the burial - transit	ia E	d							
'60, ate be exphysician	Medical		MENDED  23c. If yes, outcome of pregnance					23d. Date of de	divor
687 ertifica ding ph	ian/N	23b. Was decedent pregnant in the past 12 months?	Live birth     Pregnant at time of death	2 Fetal	death 3	Ectopic preg	nancy	Month	Day Year
O. Box 687 at the death certific dby the attending perache for use as the	Physician/	1 Yes 2 No 9 V Unknown	9 Unknown	5 Othe	(Specify)				
P.O.	by P	Part II. Other significant conditions co	ntributing to death but not result	ting in the und	lerlying cause	given in Part I.	23e. Did to		te to the cause of death?  Probably 4 Unknown
ds, Fequires	ed		<u>.</u>				- 24a. Was a		re autopsy findings available
ecor ne law i te has b	Completed						_ autops perform 1 ✓ Yes 2	m <u>ed</u> ? dea	r to completion of cause of th? Yes 2 No
al R ian: Ti certifica ctor, pa	Bec	25. Was case referred to medical examiner?			26.Place	e of Death (Chec			165 2 100
f Vit Physic er this c	ા	1 Yes 2 No  27. Manner of Death		Outpatient 3				Residence 6 🗸	Other: Scene
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Certification:	1 Natural 5 Pending 2 Accident Investigation	FOUND: Day, Year) FO	o. Time or inju DUND: 45 hrs_		ıry at Work? Yes 2. ✓ No	Subject assa	ow injury occurred aulted	
Divis tal or A us after al Direc	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, (Specify) Single Family			ouilding, etc.	or Town, St		or Rural Route Number, City
the Hosp iin 24 hou the Fune ipletely fi	Medical C	29a. Certifier 1 Certifying Physician:	To the best of my knowledge, d	leath occurred	d at the time, d		nd due to the cause	e(s) and manner as	stated.
To To Com	Meo	29b. Signature and title of certifier	d manner stated.		29c. Licens		-		(Month, Day, Year)
		AM C	6 m		O.C.	M.E.		June 10, 201	0
5		30. Name and address of person who com Russell Alexander MD. As	plated cause of death (Item 23a sistant Medical Examine		enn Street,	Baltimore, I	MD 21201		
St Regist		31. Date filed (Month, Day, Year)	32. Fegistrar's Signature	Soar					
		- JUN 1 D ZUIL	Supplement for	THE PERSON	-		CUIVIE		

director, Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 🗸 Yes ို 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 No To the Funeral Director: completely filled in by the Fd 6/6/10 Fd 1315 hrs Accident Investigation  $\begin{array}{ll} \text{Location (Street and Number or Rural Route Number, City} \\ \text{or Town, State)} \ 5103 \ Buttermilk \ Rd \end{array}$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined residence 4 Homicide Pylesville, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

and manner stated.

30. Name and address of person who completed cause of death (Item 23a

32. Registrar's Signature arka 29d. Date signed (Month, Day, Year)

June 7, 2010

Death

Year

Division

29c. License number

O.C.M.E

/ 111 Penr Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10a-c,e,f,perINF,g905,7/15/2010,wS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June ROCCO FRANK 2010 рМ 4:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Annapolitan Assisted Living Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 F Hours Min. (Month, Day, 108-12-5120 93 Director Apri Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location New Smyrna Beach 10d. Inside City Limits Volusia Florida Director 1 🗌 Yes 2 🗶 No 10f. Zip Cod 2168 2616 Brookline Ave. 10g. Citizen of What Country? Funeral U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural", Specify: Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director of Building Management Veterans Administration 0 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Patsy Rocca Clara Sosa i and 2 should b f Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Rocco (Daughter) 3472 Old Crown Drive, Pasadena, Maryland 21122 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State emetery, crematory or other place Atlantic Crematory June 16, 2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one caus on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? this certificate 25. Was case referred to medical examiner? Hospital or Attending Physician: ector, 26. Place of Death (Check only one) Assisted Be Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the h Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature title of certifie lame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ Ruffin IÖ 010*S* Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Johns Hopkins Bayview Medical Centur Baltimore Social Security Number Funeral if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Month Day Director Usual Residence of Decedent or 28a-f show of Health and Mental Hygiene. item "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County within 72 hours after death with the Maryland Oc. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No 3 ₩Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) econday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Be Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau tarrison Baltimore, Method of Disposition 20b. Place of Disposition (Name of 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Strvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dvird, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stroke Physician, days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death g ☐ Unknown the hed s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21224 Avenue State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, Day 2010 Year Robert Drury Rafferty, Sr. 8:05 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15209 Emory Lane Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. November 7,1931 Washington, D.C. 1 🗶 M 2 🗆 F Hours 78 577-40-0161 Director Usual Residence of Decedent your i permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must has matifical at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15209 Emory Lane 20853 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forces Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1951–1953 1 ☐ Yes 2 X No Specify. Specify.White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Drywall Contractor Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph A. Rafferty, Sr. Rippard Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret I. Rafferty / Wife 15209 Emory Lane, Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔣 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Gate of Heaven Cemetery June 17, 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville Inc. 300 .W. Montgomery Avenue, Rockville, Maryland M01596 20850 23a. Part 1. Lefter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 X No prior to completion of cause of death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: ٥ 1 🗀 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year) MD00060050 June 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850

DHMH 17 Rev 7/2009

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Registrar

parle

M.D.

32. Registrar's Signature

Mahrukh Hussain, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard E. Rayford Physician/ Day June 2010 Year 8, 6:05 РΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 I Months Days Hours Min. Feb. 10, 394-18-1580 <sup>Y</sup>f 923 Director 87 Wĭsconsin Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits with the Maryland Director RAYFORD Maryland 1 ☐ Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 8506 Country Club Drive 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ğ 1 ☐ Never Married 2 🖾 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed WW II Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rayford Hattie Quandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark E. Rayford/Son 8506 Country Club Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of Mon Lgome ry, crematory or other place) 20a. Method of Disposition June 13, 20c. Location - City or Town, State 1 🔲 Burial 2 🛭 Cremation 3 🗆 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Cremătorium, Inc. Bethesda-Chevy 21. Signatur Fuyeral Solice Licensee Robert A. Pumphirey Funeral Home/ 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48 hours Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year ned by the a e detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signe should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No 1 A Inpatient 2 ER/Outpatient 3 DOA မ funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? e Funeral Director: Aft bleted filled in by the fur 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D70144 June 9, 2010 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) Michael Murray, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Emmaline Lee Roberts June 6, 2010 1825 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Examiner Frederick Edenton Retirement Center Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 15, 1925 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 🗷 Idaho 85 Director 5 8 - 22 - 57 Usual Residence of Deceder Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examiner must be retified. 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location 1 ☐ Yes 2√√ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5901 Genesis Lane 21703 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Force 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 □Yes 2√√No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Emma A Deuth မ Ernest L. Berry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Rockwell Terrace, Frederick, MD 21701 Carolyn Roberts 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory June 8, 2010 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Fink Funeral Home, P.A. 21. Signature Funeral Service 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the diseas shock, or heart failure mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Can e (Final disease or con in a resulting in death) **Physician** Preumani /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physiclan for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year certificate has been signed by the rector, page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6X Other (Specify) this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury 28c. Injury at Work? After 5 Pending investigation Natural 2 Accident death. 1 ☐Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely atule and title of certifier 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Thonson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

JUN 162010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#20a&22perFH, G904, 6/16/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth O (Month) 9ay, Year 994 last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F MaryTand 214-43-1099 15 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Suitland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6284 Maxwell Drive 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education the Medical 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) none none injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Scott Sr. Shawn Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Shawn Adams - mother 6284 Maxwell Drive; Suitland, Maryland 20746 permit. Pages 1 am Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation Cremation 3 Removal from State Resurrection Cemetery 6-21-2010 Clinton, MD. Licensee Wade Director 22. Name and Address of Facility Marshall's Funeral Home 4308 Suitland Rd. Suitland MD. 20746

To compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Ronald Approximate Interval Between Onset and Death Enter the disease or complications that caused to or heart failure. List only one cause on each line shock Immediate Cause (Final HEART **Physician** disease or condition resulting in death) GRAFT /Medical Due to (or as a consequence of) **Examiner** ART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2-No 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 3 🗌 DOA ၉ 2 ER/Outpatient 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury Time of 28d. Describe how injury occurred Director: After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and magner stated the 29b. Signature and 10 29c. License number 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

CROFT

32. Registre

's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .June 201 gar 00:30 a M CARRIE WILSON SETTLE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 M 2 X Aug. 23, Year 1929 NC Yrs Director 241-46-3514 80 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Forestville MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ? is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be Funeral 20747 USA 7420 Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Private Duty yrs permit. Page 1 and 2 should be filec.
Department of Health and Mental Hy.
Important: If item 27 is marked other any injury or other traumations. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Mullins Willard Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7515 Grouse P1. Landover, Md. 20785 Bessie Stephenson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Metropolitan Crematory 6-10-2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 21. Signature of Funeral Service Licensee Marshalldes of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Day Year Pregnant at time of death detached the Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Fai hour completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

within 24 hours a **Fo the Funeral L** 

29a. Certifier

29b. Signature and title of

Name and add

chard

31. Date filed (Month, Day, Year,

South

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MI)

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B23

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D00 55120

2010

em avenue SE Sunto 310 Workington De 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 15 Day 2010 ar 10:13 A M Richard W Sutton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1740 Ruppert Dr. Finksburg Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral New York Days Hours Min. 1**X** M 2 □ F 82 4/5/1928 059-22-3394 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ä Director 28a-f Examiner must be notified 1 Yes 2 X No Carroll Finksburg ъ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1740 Ruppert Dr. 21048 United States tems death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o, þ 1 Never Married 2XXMarried 1 X Yes 2 □ No 1950within 72 hours after Maryland 21215-0036 1 ☐ Yes 2x No Specify: White Specify: "natural" 3 Divorced Completed 1954 Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Alban Tractor Co. 12th Sales Manager permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon E. Sutton, MD Ruth Farrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1740 Ruppert Dr. Finksburg, MD 21048 19a. Informant's Name/Relationship (Type, Print) Patricia A. Sutton (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Carroll Crematory ! 6/16/2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of 5 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. Old Liberty Rd. Winfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. signed k d be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, The law requires 3 Debably 4 Unknown Completed 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🕶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After i
completed filled in by the funera 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Street Wistminster MD 21157

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan	-			and M	lental Hyg	iene	1 18778
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Jeatn			eg. No.	7 10710
	Physicia	ın/						<ol><li>Date of Deat Month</li></ol>	Day Yea	3. Time of Death
	Medic		Matthew James Smith, Jr.  4a. Facility Name (if not institution, give street and number)		41 OH T			June 9		12:45P
	Examin	ier	2407 Baldwin Mill Rd.		4b. City, Town, or	lston 1ston			4c. County of De	eath ford
			5. Social Security Number 6. Sex 7. Age (In yrs. le	nt hirthelass)	If Under 1 Year			O Data of Blath		
	Funeral Director		1 X M 2 DE	Yrs.	Months Days	Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year) (	Birthplace (State or Foreign Country)
			218-28-3645 77 Usual Residence of Decedent			L		August	26,1932	Maryland
	and shov	5		, Town or Loc						10d. Inside City Limits
	Aaryla Ba-f Lifiec	Director	Md. Harford		Forest	Hill				1 ☐ Yes 2 🖁 No
	or 2	₫	10e. Street and Number		10f. Zip Code			1	0g. Citizen of What	Gountry?
	with 23a 1st b	Funeral	1612 B Denise Dr.		21	050			USA	
	tems er m	듄	11. Marital Status 12. Was Decedent Ever in U.S		as Decedent of H	ispanic Ori	igin? (Spec	cify Yes or No-	14. Race - Ar	nerican Indian,
ဖွ	ter d , or i	ğ	1 ☐ Never Married 2 ☐ Married Armed Forces?	i i	Yes, specify Cuba			Rican, etc.)	Black, Wi	in a contract of
8	ural"	ed	3 ☐ Widowed 4 【 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:	:		Specify:	White
2-0	2 hot	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup ind of work done o		t of workin	ng	16b. Kind of Busines	ss Industry
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2	ygier her t it, th	Be C	12th	Appra	iser				Residenta	l Property
ğ	e filer ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last)						laiden Surname)	
<u> </u>	Men Men narke	-	Matthew James Smith Dr.			Kat	herin	e E. Fo	ehlinger	
Jai	shou and ris n		19a. Informant's Name/Relationship (Type, Print)						City or Town, State,	
dî	and 2 lealth im 2 her t	- 1	Tracey Grossman			Mill	Rd	Fallsto	n, MD 210	47
0	toff Fite or ot				sition (Name of atory or other plac	e)	D	ate	20c. Location - City	or Town, State
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.			rrison	Forest		6-16-	-2010 Ow	ings Mill	s, Md.
šai	ermit eparl npor ny in		21. Signarul of Funeral Service Vicensee	22.	Name and Address	s of Facilit	ty Sch	imunek	Funeral H	ome ofBelAir
ш			Dur D. Jeans	I1	nc 610 W.	Mac	Phail	. Rd Bel	Air, MD 2	1014
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	r the mode of dying	g, such as	cardiac or	respiratory arre	st,	Approximate Interval Between
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	Medical Examiner		resulting in death)  Due to (or as a care a unit							[ ] W [ [ ] · · ·
		L.	Sequentially list conditions, b.							
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9	cate be executed physician and sthe burial-transit	edical	d							
_	death certificate ne attending phys ed for use as the		IF FEMALE:							
29 XOE	th cel	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal	death 3 🗌		у			23d. Date of	
n	deat the at	Physician/M	1   Yes 2   No 4   Pregnant at time of dog Unknown 9   Unknown	eath 5 🗌	Other (specify)				Month	Day Year
л Э	at the	Ph	Part II. Other significant conditions contributing to death but not resu	Ilting in the ur	derlyina cause aiv	en in Part I		O2a Didaah	need transportation to	to the cause of death?
7.	es tha	l by		nerig in the di	identyling oddoo giv	on mir acc				4.
g	een s bould	stec						1 L Ye	s 2   NO 3	Probably 4 Unknown
8	law n las b	Completed						24a. Was an autops	y prior t	autopsy findings available o completion of cause of
e Y	The cate h	S						perform	ned? death'	es 2 No
<u> </u>	cian: ertific ector,	Be	25. Was case referred to medical examiner?  Hospital:			ace of Deat				Tau Mayer
5	hysi this c	은	1 Inpatient 2 E			er: 4 🗌 Nu	ursing Hon	ne 5 🗌 Reside	nce 6 Other (Sp.	ecify Colonic
<u></u>	ing F	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	2	8d. Describe how	w injury occurred	
0	tend Jeath tor: / the f	<u>i</u> įį	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2 🗆	No			
Division of Vital Records,	or Al	Fe	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		2	8f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
5	oital ours a eral [						- 12			
	Hos 24 hc Fun	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	and/or investig	gation, in my opinio	n, death oc	curred at t	he time, date and	I place, and due to the	e cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: To the Funeral Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Ž	only one) 3 Certifying Nurse Practioner: To the best of my 29b, Signature and title of certifier		200 Liconno	number			1d Data signed (Mos	oth Day Voorl
	F 3 F ŏ		1 2024 0 1 1 0000		The second	18171	•		Y and FILL	Tay, reary
	'		"Heave were	00-) (**-	lus	10121	<u></u>		20-13-10	
	le		30. Name and address of person who completed cause of death (Item: + COTN; - D MCNNUCL W	23a) (Type, Pr	(XPO)	0. 57	- B	altin	re mo	21201°
	Stat			ired -	- CA CEST					
	Registra		31. Date filed (Month Der Year) 6 2010 32 Jegistrar's Signatu	D. 196	upland					

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fixed to a sorter traumatic event, it is fixed to a sorter traumatic event. Sichette, Anthony Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

2

Physician/Medical Examiner

Medical Certification: To Be Completed by

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

Examiner

**Funeral** 

Director

/Medical

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Plea	se Type or Pri							•		_	le.		
For State Registrar		State of M	laryland		artment <i>rtificate</i>			ınd N	lental Hy	/giene Reg. No	0.01		18	779
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		, give street and number	')		4b. City, To	wn, or l	Location of	f Death	00.,0		County of			
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Immediate Cause (disease or condition resulting in death)  Sequentially list con if any, leading to immediate. Enter Under Cause (Disease or it that initiated events resulting in death) L	nditions, mediate rlying injury	Due to (or as Due to (or as Due to (or as de Due to (or a	E m	ence of):	rhyth dial tery o	nio	hen ease	vidi	ogenic	sho	ock_			
IF FEMALE: 23b. Was decedent in the past 12 t 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal	death 3□	☐Ectopic pre☐Other (spec						23d. Date Mont		-	Year
Part II. Other signifi	icant conditio	ns contributing to death	but not resul	ting in the ur	nderlying cau	se giver	n in Part I.					oute to th	ne cause of c	death? Unknown
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2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6	ation of be	jury - At hor tc. (Specify)	ne, farm, stro	eet, factory, c		es 2□N		28f. Location City or To			r or Rura	al Route Num	nber,
29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physician: To the bes Examiner: On the basis and manner s	of examinati	rledge, deatl on and/or in	h occurred at vestigation, i	the tim	e, date an	d place, th occur	and due to the	e cause(s	) and mar d place, ar	nner as s	stated. the cause(s	5)
29b. Signature and	litle of certifier	Li DO					number 9 Z L	18		29d. Da	te signed	(Month,	Day, Year)	
Carrie	Jam	who completed cause of	9000	Frank	,	ing va	ire I	) <sub>C</sub> .	Baltin	20re	, MD	21	237	
31. Date filed (Monti	h, Day, Year)	32. Regist	rar's Signatu	_		-								
	JUN 16	2010 Bus	un ,	1. A	arkel									

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State

Registrar

within 24 hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** amryn Mubbard 0100 Kimber 202010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mercy Medical

5. Social Security Number | 6. Sex Baltimore Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** N 1 □ M 2 K Months Hours 0 Maryland Director 20,2010 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examirer must be notified at 1 ☐Yes 2 YNo Director BaltIMORE MD BaltiMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 RadNOR 522 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than INFant Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, Item Elementary/Secondary (0-12) College (1-4or 5+) INFANT N/A Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LNKNOWN ပ္ EANENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hubbard-Mother Ba LARIENE 522 RADNOR MD 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. (a thedral 7-30-10 Baltimere MD 22. Name and Address of Facility Braziley - ASNON FUNERAL HAME New Cathedral 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MITHERE PA, 2134 W, 110W Spring Rd. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** prematuriti 11 minutes extreme disease or condition resulting in death) /Medical Due to (or as a consequence of): premature Examiner 2days rupture of membrane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) signed by the attending physician dbe detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □ Yes 2 5 completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XÎNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Dore MD Paul Kite 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

10-04389 John Harry Shaw

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Harry Shaw	1	1- For State Registrar		or Maryland	-	rtment of tificate of		id ivientai		eg. No. 201	0 18781
Physician Medical Examine	~	1. Decedent's Nam John H	e (First, Middle,Las Iarry Sh						2. Date of Deal Month June 9, 20	Day Year	3. Time of Death 1620 hrs
				ve street and number	r)	T	• • • • • • • • • • • • • • • • • • • •	or Location of De		4c. County of D	Peath
Funeral		University F  5. Social Security N		ex 7. A	ge (In yrs. Ia	st birthday)	Baltimore If Under 1 Ye	ar If Under 24	Hrs. 8. Date of Bir		. Birthplace (State or
Director		360-01-	112	м 2П  88	3	Yrs	Months Da	ys Hours M	6-24-		Country) IL
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yland -f shov	ខ្ពុ	MD 10e. Street and Nu	Baltim	ore	Du	ndalk	10f. Zip Code			0-02	1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			adow Wa	У			21222	2	יר	0g. Citizen of What our USA	Country?
er death with or items 23	ineral	11. Marital Status  1 Never Marrie	ed 2 X Married		?			ispanic Origin? ( an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - A White, et	merican Indian, Black, tc.
s after de rall', or	ر ا	3 Widowed		if Yes, Give Year or Dates:	VWII		Yes 2X N			SpecifyW h	
72 hour n "natu al Exan		Elementary/Seco		nly highest grade co College (1-4 or				ation (Give kind e. DO NOT use		16b. Kind of Busine	ess/Industry
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Physician /Medical	1		ly one cause on ea		injur		e mode of dying	, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting		Due to (or as a cons							
		Sequentially list co if any, leading to in cause. Enter Under	nmediate	Due to (or as a cons	sequence of)	):					
tted d ansit	Exall	(Disease or injury t events resulting in		Due to (or as a cons	sequence of)	):					
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38760 rtificate ling phys		IF FEMALE: 23b. Was decedent past 12 months		1 Live birth	me of pregn	ancy <sub>2</sub> Fet	al death 3			23d. Date of deli Month	very Day Year
Box 687, te death certification the attending pred for use as the by the form of the form	) SICI	1 Yes 2 1			t time of dea	th 5 Oth	er (Specify)			<u> </u>	
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n of Viding Physical ding Physical directly funeral direc	-  -	27. Manner of Deat	ZINU	28a. Date of Inj (Month, Day,	ury	28b. Time of Ir	ijury 28c. Inju	ury at Work?	28d. Describe h	now injury occurred	
Division of the of the office		1 Natural 2 X Accident	5 Pending Investigati			11:32 a	t, factory, office	Yes 2 No	subject		Pural Pauta Number City
Divi		3 Suicide 4 Homicide	6 Could not determine	De	drive		t, lactory, office	ballaling, etc.	or Town, Si Dunbrin	Rd Dunda	Rural Route Number, City Vay near alk, MD
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitival Certification: To Be Completed by Dhysician Medical Ex		29a. Certifier (Check only one) 2		r:On the basis of exa						e(s) and manner as a and place, and due t	
7. ½ ½ Ø	2	29b. Signature and	title of certifier	and manner stated	*>		29c. Licen:			29d. Date signed (	-
	-	30. Name and addre	ess of person who	completed cause of	death (Item 2	23a)	0.0	.M.E.		June 10, 2010	
		Melissa Bra	ssell, MD A	ssistant Medica	l Examine	er 111 P		Baltimore, M	D 21201		
Stat Registra	-	31. Date filed (Mont	th, Day, Year)	32. Registra	ar's Signatur	. spar	Ker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Month Physician/ 2010 Bernard Simmons 12:45p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**X**M 2 □ F Months Hours 0672541956 Marvland Director 217-56-6134 53 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 1627 E. North Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes : 2X No 21215-0036 1 ☐ Yes 2 ANO Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Disability N/A 10th Grade Be ( land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Timothy Simmons Rosie Mae Noel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 439 Pittman Place, Baltimore, MD 21202 Darlene Simmons(sister) Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth Date Josephrer Whr Prowit And Crematory 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/16/10 Baltimore, MD 21. Signature of Funeral Service Licenses Forephodes of Brown Jr. Funeral Home 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Guer Cancer Physician disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown our runeral ulrector; After this certificate has been si completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \text{ Other (Specify) HOSPICE} 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \( \subseteq \text{Yes} \quad 2 \( \subseteq \text{No} \) injury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 6/11/10 H0067817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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St. Bautimore MD

828

31. Date filed (Month, Day, Year)

North

Registrar s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:59 PM Tun 2010 0 Medical 4a. Facility Name if out institution give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A bur TOSPI timore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. 0872171941 Yrs Director 212-42-1400 68 Maryland Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2922 Carver Rd. 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Domestic N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Flossie Ward Ollie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queenie Williams(Sister) 3418 Round Rd., Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 06/18/10 Baltimore, MD 4 Donation 5 Other (Specify) Mt.Zion Cemetery of Funeral Service Licenses Joseph Adress of Brown Jr. Funeral Home P.A. 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

Funeral Director: After this certificate I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 1mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible Affend ITEM#23aptic,25,27-28a-1, perME, G919,9/22/2011, WS

Amend Item 1,23a per dr., g904,06/16/2010dhb

Certificate of Death

Reg. No. 1 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death \_Month Serafis **Physician** Steve Year JUIDO. /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 6. Sex 1 XM 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 81 17,1929 April Director 234-44-3855 Greece Usual Residence of Decedent death with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director Maryland Baltimore Baltimore County 1 ☐ Yes 2XXNo notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö must be i 21234 USA 7603 Daniels Avenue 23a Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2X XNo If Yes, Give Year or Dates:Korean Specify ⋧ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs. College (1-4 or 5+) Barber Ed's Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Michael Serafim Angela Cotsoradis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Serafis (Wife) 7603 Daniels Avenue Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important; If ite
any injury or ot XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 6~9~2010 Baltimore, Md. at re of Funeral Service-Licensee <sup>22. Name and Address of Fineral</sup> Home 7401 Belair Rd. Baltimore, Maryland Clastice 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heute respiratory sundrome disease or condition J.Stress resulting in death) /Medical Due to (or as a consi quence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed burial-transit Odontoid fracture with Complications and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ding physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 1 No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2/ No l or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: <del>a./∑i N</del>o 1 Inpatient 2 TER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred of electric Subject fell out of electric I Director: After to in by the funer Injury P 5 Pending investigation Natural 2 Accident April 29, 2010 Unknown M 1 Yes 2 X No death. chair 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide after home 7603 Daniels Ave. Baltimore, MD e Funeral the Hospital 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6~6~2010 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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		for State	State of Maryland	-			Mental Hy	giene 2 0 1 1	1 8785
		Registrar  1. Decedent's Name (First, Middle, Las	×f)	Cer	tificate of L	Jeath		Reg. No.	0,00
Physic	ian/	1. Decedent's Name (First, Widdle, La.	,	CHDC.	T.C		2. Date of Dea Month 06	Day Ye	3. Time of Death
Med Exam		4a. Facility Name (if not institution, give	HELEN M.	SUPS.	I	r Location of Dear		06 20:	
LAdill	IIICI	7841 Kings Be			1	sadena			Arundel
Funera		Social Security Number     6. S	ex 7. Age (In yrs, las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h g.	Birthplace (State or Foreign
Directo	r	166 20 6892   1	<sup>□ M 2</sup> <del>S</del> F   84	Yrs.	World Buys	Tiodis IVIII	02 13	1926	PA_
nd how	ō	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
faryla 8a-f s tified	ect	MD Anne A	rundel Pa	sader	าล				1 ☐ Yes 2 🗷 No
the N or 29	۱ä	10e. Street and Number	rander   ra	oddei	10f. Zip Code			10g. Citizen of What	Country?
ING Z1Z13-UU36  Filed within 72 hours after death with the Maryland tal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	7841 Kings Be	nch Place			21122		U.S.	A
deatl r iten iner r		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	specify Yes or No- to Rican, etc.)		merican Indian, hite, etc.
al", o	d by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 L Yes 2 M No If Yes, Give Year or Dates.	1	☐ Yes 2 🗷 No	Specify:		2	White
ZTZT5-UU36 within 72 hours after giene. er than "natural", o	Completed	15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	
in 72 han "	dwo	(Specify only highest grant (S	College (1-4 or 5+)	(Give I life. D	kind of work done o O NOT use retired)	during most of wo	rking		
d with Sygien st, the table	Be C			Meat	Wrappe				ıpermarket
YIANG Z1Z15-UU36  Jid be filed within 72 hours after death with the Maryland Mental Hygiene.  narked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)	John Kuzmi	_ 1_			me (First, Middle, I		
Marylan should be file and Mental 7 is marked or raumatic eve	ľ	19a. Informant's Name/Relationship (T			na Addroon (Stroot		Learch	ark ; City or Town, State,	Zin Cadal
Mar 12 shou alth and 27 is m r traum		Mary Sharik -			-			-	, MD 21122
1 and 1 and of Hear item		20a. Method of Disposition	20b. Pla	ice of Dispo	sition (Name of natory or other place		Date	20c. Location - City	
Page Page ant: If		1 🛛 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗆 Other (Special					4/2010	Fuller	on, MD
<b>Baltimore, Marylan</b> permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service Licens		22	. Name and Addres	ss of Facility G	J Gonce	Funeral	Home, PA
n gor#9		m/k-			69 Rivi	<u>lera Dr</u>	• Pasa	dena, M	21122
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	olications that caused the death. ne cause on each line.	Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
Physician ≀ Medica	-	Immediate Cause (Final disease or condition resulting in death)	aAdvar		Age				over 10 yr
Examine	-		Due to (or as a conseque		brillat	ion			over 1 vr
	Je l	Sequentiany list conditions, if any, leading to immediate	Due to (or as a conseque		DITITAL	,1011			OVEL 1 yl
uted d	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	6						
s be executed /sician and e burial-transit	۱ <u>۳</u>	resulting in death) Last	Due to (or as a conseque	nce of):					
ate be	dical		d						
ertifica ding p	Ĭ,	IF FEMALE:	23c. If yes, outcome of pregnance	cv					
ords, F.O. BOX 66/00, requires that the death certificate been signed by the attending physishould be detached for use as the	cian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal of 4 Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	У		23d. Date of Month	delivery Day Year
at the de d by the etached	hysi	1 Yes 2 X No 9 Unknown	g 🗆 Unknown		- (-, -, -, -, -, -, -, -, -, -, -, -, -, -				
that the the the the definition of the the the the the the the the the the	y P	Part II. Other significant conditions of		ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
dS, quires en sig ould b	ted	Hyperten	sion				1 □ \	′es 2 🗷 No 3 🗆	Probably 4 Unknown
The law requires The law been sig	Completed by Physician/Med	Hyperlip	idemia				24a. Was a	sy prior	autopsy findings available to completion of cause of
The I	Sol	Diabetes					perfor 1 Yes		n? Yes 2 □ No
VILAI ysician: s certific director,	Be	25. Was case referred to medical examiner?  1  Yes 2. No	Hospital:		Othe	ace of Death (Che	eck only one)		
Phys rthis	2	1 ☐ Yes 2. ☑ No 27. Manner of Death	1  Inpatient 2 E	R/Outpatien 8b. Time of	t 3 DOA 28c. Injun	4 L Nursing I	1	ence 6 Other (Sp ow injury occurred	pecify)
or or or or or or or or or or or or or o	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 □ No	200, Describe in	ow injury occurred	
IVISION OF INTERPRETED IN OF Attending Planter death. Director: After the lin by the funeral	Certificate:	3 Suicide 6 Could not b	28e. Place of Injury - At hom	e, farm, stre	et, factory, office				Rural Route Number,
LIVISION OF VITAL RECORDS, F.O. BOX OOF OF To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the			building, etc. (Specify)				City or Towi		
Hosp 24 hou Funer	Medical	(Check 2 ☐ Medical Exami	sician: To the best of my knowled ner: On the basis of examination a	and/or invest	igation, in my opinic	on, death occurred	at the time, date ar	nd place, and due to t	ne cause(s) and manner stated.
o the ithin 2 o the	ž	only one) 3 LJ Certifying Nurs 29b. Signature and title of certifier	se Practioner: To the best of my k	nowledge, d	leath occurred at the		1	cause(s) and manner 29d. Date signed (Mo	
F 3 F 5		D 2//1: 1/	avilli n	10					
3/5		30. Name and address of person who d	ompleted cause of death (Item 2	3a) (Type, P		061041	1	June 8.	2010
(-)					terfiel	d Rd	Glen Bu	rnie, MI	21061
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	'e					
Regist	rar	JUN 1 6 2010	anna S. de	arte					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 20th 2010 Medical Examiner 4c County of Death RNI If Under 1 Year 8. Date of Birth (Month, Day, 04 09 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1923 1 🗆 M 2 💢 F Director 87 Algeria Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy njuny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2. No MD Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7660 Pine Haven 21122 Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ August Ferudja Denise Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3316 Betterton Circle Abingdon, MD 21009 Dorothy Beasley - daughter Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Cathedral Cem! 6/14/10 4 Donation 5 Other (Specify) New Baltimore, MD 22. Name and Address of Facility GJ Gonce Funeral Home, Signature of Facilial Service Licensee PA 21122 169 Riviera Dr. Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Oue to (or as a consequence <sup>\*</sup>Examiner NOW Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □ Unknown 1 🗌 Yes 2 🗌 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 25. a case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatu son who completed cause of death (Item 23a) (Type, Print)

State Registrar

EANWIN

32. Registra

			1-	State Registrar	Certificate of Death				Reg. No. 8 7 8 7				
	Physici	an	1.	Decedent's Name (First, Middle, Las		<u>.</u> .			2. Date of Do		ay	Year	3. Time of Death
	/Medic		L	MasiE	SMA	HL			JUNE	15	t 20	010	0300 A M
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be not the Injury or other traumatic events.	:0	4a.	Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4	lc. County	of Death	
			L	248 CHESTNUT	STREET		TURNER	STATION	1		BALTI		
- 10				Social Security Number 6. S	I M 2 KIE	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Yea	(r)	9. Birth Cou	place (State or Foreign intry)
				216-28-7490 ual Residence of Decedent	102				04-2	8-1	908		MD
			$\overline{}$	a. State 10b. County	10c.	City, Town or L	ocation						10d. Inside City Limits
		tor	]	MD BALT	IMORE	TURNE	R STATIO	N					1 XYes 2 No
21215-0036		al Director	10	e. Street and Number			10f. Zip Code			10g. C	Citizen of W	/hat Cou	ntry?
				248 CHESTNUT STRE	EET		2122	2	:		USA		
		Funeral	11.	Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp ean, Mexican, Puerto	pecify Yes or No	0-		e - Ameri k, White,	can Indian,
				1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 No If Yes, Give		1 □ Yes 🏖 No		,,		Specify		
		d by	-	3X Widowed 4 □ Divorced	Year or Dates:	16a Dees	edent's Usual Occup	nation		106			
15		Completed	_	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	e kind of work done  DO NOT use retire	during most of worked)	king	160.	Kind of Bu	siness/if	loustry
12				Elementary/Secondary (0-12)	College (1-4or 5+)		OMESTIC	-/		:	HOUSE	WORK	
P		To Be C	17	. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maide	en Surnam	e) U	INK
Maryland				DENNIS BROOKS				HARR	IETT				
ary			19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								p Code)		
			]	MARION MOSS/DAUGI	HTER	24	8 CHESTN	UT STREET	,BALTIM	ORE	,MD 2	1222	<u>-</u>
ore			20:	a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐		<ul> <li>Place of Disp cemetery, cre</li> </ul>	osition (Name of ematory or other pla	ice)	Date			•	own, State
Baltimore,				4 □ Donation 5 □ Other (Specify			CREMATIO	1	•	1			D 21217
Salt			21	. Signature of Funeral Service Licen	see MA	2							IS F.H., INC
			00	yames 4	, your	1		RENS ST.,			D 212	17	Ai
				Ba. P. 1. Enter the disease, or comp shock, or heart failure. List only	one cause on e ch line.	eath. Do not en	iter the mode of dyl	ng, such as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. DEMENTA  10 YEARS										
	Examiner				Due to (or as a cons	sequence of):							
		e.	Se if a	equentially list conditions, any, leading to immediate	b Due to (or as a cons	onsequence of):						_	
.1.	be executed iician and burial-transit	Examiner	tha	ause (Disease or injury at initiated events	C								
hr	be execu ician and burial-tral		resulting in death) Last Due to (or as a consequ				uence of):						
£,09289	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical			.d								· · · · · · · · · · · · · · · · · · ·
9			IF	FEMALE:				5.5				-	
Box		ian/	23	b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F	Fetal death 3 Ectopic pregnancy					23d. Date of delivery  Month Day Year		
-		Physician/		1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown								
P.0												the cause of death?	
ds,		Completed by		AORTIC STE	VOSIS, CHA	LONIC 1	CIDNEY :	NICENSE	1 🗆	] Yes	2 <b>N</b> O	3 ☐ Pro	bably 4 Unknown
00	w req beer shou	lete	COLON CANCEL 24a. Was an 24b. Were autopsy finding:								onsy findings available		
Re	The larate has	E C	_						auto	opsy formed?	,   6	rior to co l <u>ea</u> th?	ompletion of cause of
ta	To the Hospital or Attending Physician: The within 42 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag		25	. Was case referred to medical				26. Place of Deal	1 Yes	2 24	<b>1</b> 0 1	□Yes	2 No
>		To Be		examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3□ DOA Oth		\ 4		6 ∏Othe	er (Spec	eifv)
0													
Si		atic											
Division or Vital Records,		Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Spe	At home, farm, street, factory, office 28f. Location (St City or Town					treet and Number or Rural Route Number, n, State)		
Ω		Medical Cer	-			date and place, and due to the cause(s) and manner as stated.							
			29	la. Certifier  (Check only one)  Certifying Ph  2 Medical Exam	vsician: To the best of my lainer: On the basis of exame and manner stated.	knowledge, dea nination and/or it	th occurred at the transport to the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of transport of the transport of trans	opinion, death occu	, and due to the rred at the time	e cause e, date a	e(s) and ma and place, a	nner as and due	stated. to the cause(s)
			29	b. Signature and title of certifier	and marrier stated.		29c. License number 2			29d. [	29d. Date signed (Month, Day, Year)		
	⊢ <i>≶</i> ⊢ ŏ			1 / / /	6 h		71-	2632		0	NE		2010
			30	. Name and address of person who	completed cause of death (I	Item 23a) (Type				ر) ب	NE	1	2010
	2			JENNIFER HAYA				W CIRCLI	דגם פ	πО	, MD		1224
150	Sta		31	Paris 16 20 10 Year) 2	32. Registrar's	apature /			<i></i> _	***	7 111		1224
	Registr	ar	1	/ / / /	1 7 1								

Tn the Hospital nr Attending Physician: within 24 hours after death.

Tn the Funeral Director: After this certifit completely filled in by the funeral director;

31. Date filed (Month, Day, Year 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

29b. Signature and title of certifier

Pamela E. Southall, MD

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

29d. Date signed (Month, Day, Year)

June 10, 2010

DHMH 17 Rev 1/2001

State Registrar nd address of person wbo

31. Date filed (Month, Day, Year)

600 N Worke St

Raitimore MD 21287

completed cause of death (Item 23a) (Type, Print)

cwine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Elaine Stevenson 2010 11 June 3:30 a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Martin's Home Baltimore Catonsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpic Country) MD 1 □ M 2 📭 Months Days Hours 0970871912 Director 213-28-6881 97 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Catonsville 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 601 Maiden Choice Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces
1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 2 **X**No 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 H Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances V. Whittin John F. Eckert permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 June Road, Halethorpe, Maryland 21227 William Stevenson (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holy Cross Cemetery | 06/15/2010 Brooklyn Park, Maryland Donation 5 Other (Specify) of Funeral Service License Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ ATERA disease or condition resulting in death) NEUMONIA Medical Due to (or as a consequence of): Examiner Samue titilly list over fittings Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MYELO PROLIFERATIVE DISORDER Records, 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed WITH ESENTIAL THROMBO CYTUSIS24A. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law cate has page 2 s HYPERTENS HYPOTHYROIDISM SICKSINUS SYNDRO ESSENTIAL this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital director, 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Datersigned (Month, Day, Year,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

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Ave Stello. Baltimore Md21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Kathryn Scherer 5,00 PM June 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner or Location of Death 4c. County of Death 17:00 3 N/A If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Days 1 M 2 X 09/28/1916 93 Director 213-16-9987 PA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1101 Elmridge Avenue 21229 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates Yes 2 No Specify Specify: White Completed 3

Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) other than College (1-4 or 5+) Waitress Food/Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Bardin Anderson Mary J. Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois G. Arnette (Daughter) 1101 Elmridge Avenue, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenhill Cemetery 06/16/2010 Berryville, VA 4 Donation 5 Other (Specify) Synature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to infimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or a resulting in death) Last Physician/Medical certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed upleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate Yes 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 2 Medical Examiner: On the pasis of examination arrows investigation, in my opening a second at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the within 2 dica 29c. License number 10 2 40 5 7 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 14/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Himore MD aton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Brown Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HUBBARD WHITE  $\stackrel{ ext{Month}}{ ext{JUNE}}$ 2010 JR. 2155 p 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Ft. Washington Hospital Ft. Washington Prince Geroges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min (Month, Day, Ye 430-86-4010 65 ĩ 945 Mav AR Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince Georges Lanham 1 Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6310 Martins Terr. 20706 Was Decedent Armed Forces? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Metropolitan Police Dept. DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubbard White, Sr. Elsie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin White - Son 8731 Fulton Ave. Glenarden, MD. 20706 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 6-23-2010 Cheltenham, Md. Signatur 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Ischemic Cardiomyopathy disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

**Examiner** 

**Funeral** 

Director

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permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other: any injury or other traumatic event, th

Department of Health Important: If item 27 any injury or other to once.

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner attending physician and for use as the burial-tran rate has been signed by the a page 2 should be detached f ours after death. eral Director: After this certific filled in by the funeral director, Medical Certificate: To Be

Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate

Division of Vital Records, P.O. Box 68760

	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linijury that initiated events resulting in death) Last  Hypertension  Due to (or as a consequence of):  Hyperlipidemia  Due to (or as a consequence of):  Type 2 Diabetes Mellitus													
	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   23d. Date of delivery   23d. Date of deli													
	Part II. Other significant conditions	contributing to death but not resulting in the underly	ring cause given in Part I.		obacco use contribute to	the cause of death?								
ŀ					prior to death?	atopsy findings available completion of cause of								
-	25. Was case referred to medical		26. Place of Death (Check	( only one)										
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 [	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Resid	ence 6 Other (Spec	cify)								
	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation		work?	28d. Describe how injury occurred										
	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	20a Diago of Injury At home form street for	ctory, office	28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,								
	(Check 2 Medical Exam	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
ſ	29b. Signature and title of certifier		29c. License number	4	29d. Date signed (Monti	h, Day, Year)								

D55559

June 14, 2010

Greenbelt, Md. 20770

State Registrar

within 24 hours a

DHMH 17 Rev 7/2009

7525 Greenway Center Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Thomas E. Maslen, Md

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 Day Physician/ JUNE 2010 KENNETH RICO WHITAKER 2350 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country)
 DC Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month, Day, 1 🛛 M 2 □ F Days Hours Yrs. Director 578-90-1943 49 Mar. 1961 DC Usual Residence of Decedent or 28a-f shov "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 X No MD Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5516 Livingston Terr. 20745 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 🔀 Yes 2 1979 If Yes, Give 1979 Year or Dates. 19 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced 1986 Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working than College (1-4 or 5+) Elementary/Seconday (0-12) id Mental Hygiene. marked other tha 1 yr Security Specialist Fairfax Cty Public Sch. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | မ Walter Whitaker, Sr. Judith Ester Sherrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 5516 Livingston Terr #202 Oxon Hill, MD. 20745 Stephanie Whitaker - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 6-21-2010 Cheltenham, Md. of Feneral Service Licensee Marshall s Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Colon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Day Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe 2 No Yes 2 🔀 No 1 Ves 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 XNo Other: 1 🗆 Yes ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 horor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Parel Tayount 8 D0052586 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD. 20910 Patel, MDJayanti L. 31. Date filed (Month, Day, Year) State

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DHMH 17 Rev 7/2009

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		4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital					or Location of	Death	1	4c. County of Death		
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	Be C	Guy Will						Cvnthia	Yar	icey		
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imo Page ment c		4 Donation 5 Other S	Specify:		arkwoo	d Cemet	ery J	unel9,	20 <u>10</u>	Balto.N	1d	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Realth and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service	e Licence		22.	Name and Addre	-	CRUGGS	FIIN	ERAL HO	OME	
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	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequenc	e or):							
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To To Toom	Medical	29b. Signature and title of certific	and manner : er	stated.		29c. Licer	29c. License number 29d. Date signed (Mc					
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- h		30. Name and address of person		se of death (It	tem 23a)							
2		Laron Locke MD. A	Assistant Medica			n Street, Balt	imore, MD	21201				
		31 Date filed (Month Day Voor)	22 D	onistrar's Sinn	ature							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06-01-2010 Donna Zidek 230 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 107 W. Riding Dr. Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) VA Hours 1 □ M 2 😾 F 07(Manth, DayoYear) 51 220-74-3454 Director Usual Residence of Deceden "natural", or items 23a or 28a-f shov sdical Examiner must be notified at 10a State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Bel Air 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 107 W. Riding Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Dependent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Zidek Joan Gressik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Zidek (Mother) 107 W. Riding Drive Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of P Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 06-08-2010 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Lice Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) and consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 Yes 2 9 Unknown 2 No the cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pol 1 Yes 2 No 3 Probably 4 Unknown ental retardation 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical Be funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \textstyle{\text{Residence}} \) 6 \( \text{Other} \) Other (Specify) 2. No ဂ္ 1 Tes this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural Natural
Accident 5 Pending worl 1 Yes 2 🗌 No Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Plum tree Road, Suite 102 104

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 9796 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE KATHLEEN ZEILER 2010 8:55P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD BEL ATR UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min. Sept. 26,1928 Conway, 216~28~3344 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Forest Hill Maryland Harford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 21050 USA 1701 Rich Way Unit K Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give ¾X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Madison~Bradford Elementary/Seconday (0-12) College (1-4 or 5+) Savings & Loan 2 yrs. N/A Head Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Blackwell Eva Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5501 Cynthia Terrace Baltimore, Maryland 21206 William M. Zeiler 11 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 6~17~2010 Baltimore, Maryland Ignature of Funeral Service Licenses 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Ruptured abdominal aortic aneursym disease or condition Medical resulting in death) Examiner cerebral artery intarction middle right Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Houte renal Due to (or as a consequence of): resulting in death) Last Physician/Medical respirator 68760 days IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death?
1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 XNo 잍 1 ≥ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? ☐ Accident ☐ Suicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) D0065421 June, 13, 2010 MP

Registrar

State

D:3055

0

2010

500 Upper

Chesapeake Drive, Bel Air, Maryland 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RiFistles

Christa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene of 1/10 Certificate of Death

8eq. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ Year 20/ 1649M F<u>elisa</u> Rosario Medical Arana 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Hours (Month, Day, OV . 12 Min. Country) Ecuador Director Yrs 62 212-80-8310 1947 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☒ No Maryland Frederick Jefferson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injuy or other traumatic event, the Medical Examiner must b Funeral 4915 Rosehill Drive 21755 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☑ Yes 2 ☐ No Specify: Ecuador 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Stephen Arana / Son</u> 4915 Rosehill Drive Jefferson, Maryland 21755 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State May 28, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Frederick, Maryland 2010 Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🗆 No 3 🔀 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No Yes 1 Pyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 1 Alo Other: မ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 28d. Describe how injury occurred 5 Pending injury work? Accident Investigation Suicide 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 3 🗌 only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 20/0 d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPLE IAKOWA MARGIAND V

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Physician/ 2 Day 1108M U198 Dres 2010 ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5DVing mill moni PYS Silver Omce 8. Date of Birth If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** (Month, Day, March 29, 1 □ M 2 🎛 F Months Days Hours Min. Pennsylvania 579-48-0380 1933 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Silver Spring 1 Yes 2 No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? USA 10e. Street and Number Funeral 20902 2901 Plyers Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. White Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. "natural", 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other the any injury or other traumatic event, the I Catholic School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine E. Dalesio Robert R. Aluise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1545 Marsh Wiren Lane, Naples, FL 34105 19a. Informant's Name/Relationship (Type, Print) Joseph R. Aluise/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery June 4 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21, Signature of Funeral Service Licenses Part 1. Inter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition Ph\_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician sched for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Y Unknown tor: After this certificate has been the funeral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1X Natural 5 Pending 1 Ves 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the F only one Gignature and title of certifier 29b. MI DINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHE MO DME 31. Date filed (Month, Day, Year) Registrar's Signatute State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Zelo 9:25 Leonid Baskin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth Month, Day, Yea. 5/26/1940 9. Birthplace (State or Foreign Country) Ukraine 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Hours 1 X M 2 D F Director 219-55-3575 69 Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director within 72 hours after death with the Mary 1 Yes 2 X No Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20251 Maple Leaf Court 20886 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) "unknown" "unknown" Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F. ျ Michail Baskin Bronislava Kavnackaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 20886 Andrey Ovchinnikov, son 20251 Maple Leaf Ct, Montgomery Village, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garden of Remembrance Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike. Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final add noccy Ginoma Metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPO 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate hecompleted filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🖪 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE RO RUCKUILLE

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MayPhysician/ 2010 8:35 PM Elizabeth O. Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arunde1 1313 Tyler Avenue Annapolis 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days Hours NOVIH, Pay, Year 26 Maryland 1 □ M 2**X** F 83 219-12-3190 Yrs Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🄀 No Maryland Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 1313 Tyler Ave permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene 1 Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event the Marian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 9th Cook Annapolitan Club Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Annie Simms Frednand Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 Yvonne Spencer(Daughter) 1313 Tyler Ave Baltimore, 20b. Best togaste (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 6-2-10 Memorial Park Annapolis, Md. 4 Donation 5 Other (Specify) Marne Faces Cof Salit Sons Mortuary, F.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bètween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) evere evo Medical Due to (or as a gonsequence of) Examiner ele Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending popular to the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 I Inknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes Deen 24b. Were autopsy findings available 24a. Was an e Hospital or Attending Physician: The law 1 24 hours after death. 9 Funeral Director: After this certificate has t has i prior to completion of cause of death? page 2 performed? 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner?

1 Yes 2 10 26. Place of Death (Check only one) the funeral director, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 [ 29d. Date signed (Month, Day, Year) 29b. Signature erson who completed cause of death 30. Name and (Item 23a) (Type, Print

State

Registrar

1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 JOHN RICHARD MAY 29 3:30A BENEDICS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 6. Sex 1 🕅 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16, 1925 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. Mary Land **Director** 219-12-4655 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Le snould be flied within 72 hours after death with the Maryland saith and Mental Hygiene.

1.27 is marked other than "natural" ~-" r traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? Funeral 21771 204 Oak Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1945-47 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper 12 Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Junken Benedict Margaret (NMN) 01ds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant; If item 27 is 204 Oak Street, Mount Airy, Maryland Marilyn B. Benedict, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important; If it
any injury or of 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia Metropolitan Crematory 5/30/2010 21. Agnature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. E or the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ( aus ) (Final Physician/ CARDIOMYOPATHY disease or condit resulting in d Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -tran that initiated events resulting in death) Last Due to (or as a consequence of): the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retarded.

Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VENTRICULAR TACHYCARDIA, TTA/CVA, MYELODYSPUASA 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of ATRIAL FIB, CHF, NEUROPATHY, POLIO 24a. Was an performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 🗷 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MO 021936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHNEON DR FREDERICK, MY 21702 A. DONELSON MO 65 C THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Lee Bul1 May 31, Day 2010 12:02 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1106 Johnson Road Wicomico Salisbury 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 ื F 217-52-2458 61 0672271948 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1106 Johnson Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🄀 No Specify: "natural", Specify: white 3 M Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) certified nursing assistant health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental H E: If item 27 is marked ot Doris Lee Marshall ည Warren A. Moore 19a. Informant's Name/Relationship (Type, Print)
Randy Marshall/brother 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32214 Shavox Rd., Sallsbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date rtment of h Page 1 1 Burial 2 X Cremation 3 Removal from State njury or 6/07/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD Sign ture of Funeral Service Licensee HATING THE HOME Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Metastah Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) and I-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last y physician ar Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No of Vital Physician; completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🛚 Naturai 5 Dending injury work? death. 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

Division 24 hours after deat e Funeral Director: To the within 2

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

walan

Christjon Huddleston,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year, 2016

29c. License number D29105

106 Milford St., Salisbury, MD 21804

10-04042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Shawn Douglass		1- For State	State of I	Marylan		artment o		and I	Mental H		Don No			
Physicia Medical Exami	in/	Registrar 1. Decedent's Name (First, Shawn	Middle,Last) Douglas	Br	own					2. Date of De Month May 27,	Day Y	ear	3. Time of Death 0350 hrs	
partie on .		4a. Facility Name (if not ins		et and numb	er)		4b. City, Tow Delmar	n, or Loc	cation of Deat		4c. Count		n	
Funeral Director		5. Social Security Number 219–35–5897	6. Sex		Age (In yrs.	last birthday) Yr	If Under 1 Months	Year Days	If Under 24Hr Hours Mir	n.	8. Date of Birth(MM/DD/YYYY) 9 06/21/1984		thplace (State or grant of the state of the	
nd show any se.			State 10b. County 10c. Ci					city, Town or Location				1		
vith the Maryland s 23a or 28a-f show a notified at once.	Director	10e. Street and Number 29888 Brigh	nton Cou	rt		10f. Zip Code 21875				10g. Citizen of What Country?			ntry?	
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 3 Widowed 4	Married 12.  Divorced If Ye or D	Was Decedo Armed Force Yes s, Give Year ates:	es? 2 X No	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ric				o Rican, etc.)	ify Yes or No- 14. Race - American Indian,			
5-0036 lted within 72 hours Hygiene. I other than "natus	Completed	15. Decedent's Education  Elementary/Secondary (  12  17. Father's Name (First, M	D-12) (	chest grade of College (1-4		during n		g life. DO Ctor		tired)	16b. Kind of E	stru	ction	
21215- 21215- buld be filed Mental Hyg marked ott	Be	Douglas Lair  19a. Informant's Name/Rela	rd Brown			10h Mailin	a Addroop (		Tamel	a Jean		,	Zin Code\	
MD 2 nd 2 shoul alth and N m 27 is n	스	Tamela Brown 20a. Method of Disposition		-11110)	Lagh		W. Sch	umak	er Man		Salisb 20c Location	ury,	MD21804	
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Balti permit. Departi Import		21. Signature of Funeral Se	11. U	dom	MCC	) )	OT PUO	M HI	TT Ka.	, Sails	soury, m	$D \subseteq T$	Association 804	
Physician /Medical Examiner		23a. Part I. Enter the disea failure. List only one of Immediate Cause (Final di- or condition resulting in de	cause on each linguisease a. Intra	ons that caus ie. ioral Gun: o (or as a co	shot Wou	ınd	the mode of d	ying, suc	ch as cardiac	or respiratory a	rrest, shock, or h	eart	Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	hysician/Me	IF FEMALE: 23b. Was decedent pregnar past 12 months?  1 Yes 2 No 9	A im Alma	= -	t at time of c	2 Fe	etal death ther (Specify)		Ectopic pregn	ancy	23d. Date Month		y Day Year	
s, P.O. nires that the signed by t	d by PI	Part II. Other significant of	onditions cont	ributing to de	eath but not	resulting in the	underlying ca	use give	n in Part I.		tobacco use con es 2 🗸 No		the cause of death? bably 4 Unknown	
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<b>9</b> 5	M	29b. Signature and title of o	len	4) eted ause	of death (Ite	m 23a)		cense no		29d. Date signed (Month, Day, Year)  May 28, 2010				
SU	ate	Laron Locke MD.  31. Date filed (Month, Day,	Assistant	Medical E		111 Peni	Street, B	altimo	re, MD 212	201				
Regis	tate	AUK,	U 2.2010	A Dist	الملا	1. 1								

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								City, Town, or Location of Death			titay 21, 2	4c. County of	of Death	
		495 Innerloop @ Exit 36						Bethesda				Montgor	Montgomery	
Funeral		5. Social Security Number	rs. last birth	nday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD/YYYY	9. Birt	hplace (State or		
Director		218-46-6834	1 M 2X F	62	,	Yrs.	Months	Days	Hours	Min.	12-26	Foreign		
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21 ould b i Mer s mar	To	19a, Informant's Name/Relations			19b	Mailing	Address	(Street	and Numb	er or Ru	ral Route Nun	nber, City or Tow		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		David Blair -	Husband		24	635	Port	er M	ill I	Road	, Hebro	on, Mary	1an	d 21830
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other S			remat			o 1 m o	2770	6-2	-2010	Delmar	. D.	21 211222
- 230		21. Signature of Funeral Service		7//	Temat	22. Na	ame and A	ddress o	of Facility			neral Ho		elawale
Balt permit. Depart Impor injury		Wholeren 10	recel 1	Vabo	2	705	E. 1	Main	Stre					and 21804
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Examiner		or condition resulting in death)	Due to (or as		ce of):									
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O, e be executed ysician and burial - transit	edical	UNPENDED	AMENDED											
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OX 6876(eath certificate attending physeries attending physeries as the b	ian/M	past 12 months?	I _ LIAG	birth nant at time o	2 of death =	-	al death	3 _	_Ectopic p	pregnand	СУ	Month	D	ay Year
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	cal	(Check only	hysician: To the be miner:On the basis											
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	2	29b. Signature and title of certifie	51									May 28, 20		mi, Day, real)
Mal		0-10-						O.C.M				Iviay 20, 20	10	
AP		30. Name and address of person				444	D 0	tra=t '	Dalki	- NAI	21201			
*		Donna M. Vincenti, M				111	renn S	ıreet, l	Baltimor	e, MD	21201			
S Regis	tate	31. Date filed (Month, Day, Year)	32. R	Registrar's Sig	i lature		and a							

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Physician/ Elizabeth Bailey June 7:05P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13410 South View Road Charles Newburg Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Month, Day, October 14 .1<u>921</u> 1 - M 2 - F Maryland Director 220-26-6697 88 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13410 South View Road 20664 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 24 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allie Welch Edna Toretta Penn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeannie Burks/Daughter 8751 Dove Drive, Bel Alton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Ghost Cemetery 6/5/2010 Issue, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup>AREHART ECHOL'S FUNERAL HOME, P.A. M01458 Mary's Ave. La Plata.MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lun cance disease or condition resulting in death) 1cho carcin yea 011 Medical Due to (or as a nsequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examin and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should 24a. Was an autopsy performed 1 Yes 2 1 24b. Were autopsy findings available prior to completion of cause of death? this certificate has page 2 1 🗆 Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Telegraphy Residence 6 Other (Specify) 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 🗌 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director /
completed fille in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examine in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Fractioner: To the best of try knowledge, death oncome unity one **Certifying Nurse** ed at this time, data and place, and durate the cause (s) and man we as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0033426 30. Name and address of person was contipleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, 10)

Larry Jenkins, M.D. P.O. Box 2665, La Plata, MD

3 2010

### 10-04152 Jiannini Blanco

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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	State of Manyland / Department of I	Health and	Mental Hygien	0

Jianinini Bianco		1- For State Registrar	Otate	or Marylanu	•	ficate of <i>E</i>		id Wichte	ai i iygic		g. No.	U BEUL
Physicia	an/	1. Decedent's Nam							M	ate of Death	Day Year	3. Time of Death
Medical Exami		Jiannina 4a Eacility Name (	Blanco	ve street and number)		T <sub>4b</sub>	City Town	or Location of		ay 31, 20	4c. County of De	1145 hrs
		201 Univers		, ,			Silver Spri				Montgomery	
Funeral Director		5. Social Security N 218-35-24	00	Sex 7. Ag	e (In yrs. last 18		If Under 1 Ye Months Da		A 4'-	Date of Birth	1992 For	Birthplace (State or eign Country) D.C.
du di	-	Usual Residence o 10a. State	f Decedent 10b. County		10c. City, To	own or Location						10d. Inside City Limits
nd show s	'n	Maryland	Mont	gomery	Silv	ver Sprin	g					1 Yes 2 No
ı the Maryla 3a or 28a-f otified at o	Dire	10e. Street and Nu 201 Unive	mber ersity Blvd	., West			0f. Zip Code <b>0901</b>			10	g. Citizen of What C	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marri  3 Widowed		12. Was Decedent Armed Forces? 1 Yes 2 d If Yes, Give Year			specify Cuba	lispanic Origin an, Mexican, F lo s <i>pecify:</i>	Puerto Rica	n, etc.)	14. Race - Arr White, etc Specify: Wh:	
ours aft atural" tamine	å P			or Dates: only highest grade con	npleted) 1	6a. Decedent's	Usual Occup	ation (Give kir	nd of work o		16b. Kind of Busines	
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21215-0036 21215-0036 Judi be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be		lo Blanco					Damas	a Erli	nda Aya		
MD 2' d 2 should Ith and Me In 27 is ms numatic e		19a. Informant's Na Armando Bl	anco/Fathe	• • •		8707 B	radford	Road, S	ilver	Spring,	per, City or Town, Sta MD 20901	
Baltimore, permit. Pages I an Department of Hea Important: If iter			<u>-</u>	Removal from Sta	ate cre	ice of Disposition in atory or other of Heav	place)		June 201	5. l	20c. Location - City Silver Sprin	or rown, State
Balti permit Departi Import injury		21, Signature of Fu	la us	a Oct	کسر						Inc. Spring,MD 20	and the second s
Physician			ly one cause on e			o not enter the	mode of dying	g, such as car	diac or resp	oiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause ( or condition resulti		Asphyxia by har								Deadil
	_	Sequentially list co		Due to (or as a conse	outence of).							
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cuted nd transit	Ĕ	events resulting in	death) Last	•								
be exection a sician a surial - 1	Medical	UNPENDED		AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or detail gradient To the Hospital or certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent past 12 months			ne of pregnar	2 Fetal	death 3	Ectopic p	oregnancy		23d. Date of deliv Month	ery Day Year
b. Bc the dea	Phys	Part II. Other signi		3 Olikilowii	n but not resu	ulting in the und	erlying cause	given in Part	1.	23e. Did tob	acco use contribute	to the cause of death?
, P.C res that signed	d by				_					1 Yes	2 No 3 P	robably 4 Unknown
Division of Vital Records, P.O. tal or attending Physician: The law requires that the start cleath.  *I Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detach	Сотріете								_ [	24a. Was ar autops perforn Yes 2	y prior t ned? death	
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OD C ending sath. or: Aft	tion	1 Natural	5 Pending	FOUND: Day,Y	ear) F	OUND:		Yes 2 🗸 N	lo Sub	ject hang	ed self	
Divisior ital or Attendurs after death ral Director:	Certification:	Accident  Suicide  Homicide	Investiga  6 Could no determine	28e. Place of In	jury - At hom		actory, office	building, etc.	- 1	or Town, Sta		Rural Route Number, City ring, MD
Division of Vital Division of Vital With Bospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 2		er: On the best of mer: On the basis of examination and manner stated.								
F \$ F 8	M	29b. Signature and	title of certifier	1	. C	1		se number			29d. Date signed (A	fonth, Day, Year)
<b>•</b>		all	M		and by (1)		0.0	.M.E.			June 1, 2010	
		Zabiullah A	•	completed cause of d istant Medical Ex	aminer	111 Denn	Street, Ba	ltimore, MI	D 21201			
St Regist	ate rar	31. Date filed (Mon	n 0 2 201	0 Registra	's Signature	park		-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#17, 18, 1900er INF, 6-11-2010, BM/Opertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bea11 Muriel 2010  $\mathbf{A}^{\mathsf{M}}$ 7:33 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery Sunrise of Montgomery Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days West Virginia 1 🗆 M 2 🗓 F Hours Min. 08/14/1924 85 Director 216-22-2176 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County Director "natural", or items 23a or 28a-f si edical Examiner must be notified 1 Yes 2 X No Maryland Montgomery Village Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20886 United States 19310 Club House Road #202 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 NIH Technician Be Father's Name (First, Middle, Last) Wilbur Hottinger Hilbert Hottinger 18 Mother's Name (First, Middle, Maiden Surname)
Florence Virginia Brady
Florence Virginia Bread ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 770 19a. Informant's Name/Relationship (Type, Print) 4645 Lynn Burke Road Monrovia, Maryland 20771 Benjamin Beall (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 04 1 XBurial 2 Cremation 3 Removal from State 2010 Monocacy Cemetery Beallsville, Maryland injury ( 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Lice Volen 10 East Deer Park Drive Gaithersburg, MD. 20877 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or jeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Luse (Final Physician Myocardial Infarction Minutes condition Medical resulting in death) Due to (or as a consequence of Examiner Idiopathic Pulmonary Fibrosis Years Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Years Alzheimers Dementia attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? cate has by page 2 s prior to completion of cause of death? 1 Yes 2 No After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 June 01, 2010 D37391

Registrar

State

30. Name and address of person who

31. Date filed (Month, Day, Year)

Suhair Abulfarag M.D.

JUN 02 2010

Frederick Avenue #413 Gaithersburg, MD. 20877

oleted cause of death (Item 23a) (Type, Print)

604 S.

\$2. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		For State			nd / Dep	artment of I	Health and	Mental Hyg	giene		10000	
Physic	rian	1. Decedent's Name (First, Middle	e, Last)	D - 4 - 1		rtificate of	Deam	2. Date of Dea	Reg. No on the Day 201	Year	3. Time of Death 1:35 A M	
/Med		Eloise		Batch	ne lor						1:33 A M	
Exam	iner	4a. Facility Name (If not institution		number)		4b. City, Town, o	or Location of Deat	h	4c. County of Death			
<i>x</i> -		Manor Care W  5. Social Security Number	heaton 6. Sex	7 Age /ln vi	rs. last birthday)	Wheaton If Under 1 Year		8. Date of Birtl		tgom		
Funera Directo		229-24-0324	1 ☐ M 2 🔀 F		85 Yrs.	Months Days		6,1925		olace (State or Foreign ntry) t Virginia		
	•	Usual Residence of Decedent						APILI Z	0,1923	WES	r viiginia	
yland now		10a. State 10b. County		10c.	City, Town or Lo	ocation				1	0d. Inside City Limits	
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or 28	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?	
th will	Funeral Director	403 Hull Place	е				20852		U.S	.A.		
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ld be ental ked c	To Be	Raymond Akers					Berni	ce Dobbi	ns			
shoul M mar	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Stree	t and Number or R			, State, Zij	Code)	
INIC alth a 27 is	1	David Batchelor	r/Son		403	Hull Plac	e Rockv	ille, Ma	ryland	20852	2	
partilliore, intal ylating Z 1 Z 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Modical Examiner must be retified at		20a. Method of Disposition		200	. Place of Disp	osition (Name of	1	Date	20c. Location			
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		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications tha	t caused the de	ath. Do not er	ter the mode of dy	ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between	
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To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2 Medical	Examiner: On the	e basis of exam	knowledge, dea lination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LO Lot florious

31. Date filed (Month, Day, Year)

32. Registrar's Signature 20852 31. Date filed (Month, Day, Year)
JUN 0 2 2010 State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ David Bortnik 8:35a ™ May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** <u>Ukraine</u> Days 1 🛛 M 2 🗆 F Months Hours Min. 210-74-6598 77 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 X Yes 2 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16105 Crabbs Branch Way, 20855 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. , or i ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Metal Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugenia Gayisenskaya Abba Bortnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Hidden Forest Court, Gaithersburg, MD 20877 Alla Bortnik - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorah Gardens 06/03/2010 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. I Departm Signature of Folleral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate name From Underlying Cause (Disease or iinjury Examin attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 2 No 3 Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy death? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗶 Other (Specify)#03pice 1PU 1 Inpatient 2 ER/Outpatient 3 IDOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d, Describe how injury occurred 28c. Injury at work?
1 Yes 2 No 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completed filled in by the

State

Registrar

Medical

(Check

only one)

29b. Signature and title of certifier

Diane Ruckert,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP.

🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Wertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) May 31.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 28, 2010 John Wesley Buchin, Sr. 11:58 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton ( Social Security Number 9. Birthplace (State or Foreign . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. (Month, Day, Country)
Michigan 365 22 2355 Director 84 Sept\_ 1925 Usual Residence of Decedent I Hygiene. . other than "natural", or items 23a or 28a-f show vent. the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Prince George's Suitland 1 ☐ Yes 2XX No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6024 Lucente Ave 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 

Yes 2 

No
If Yes, Give 10/15 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 ır Yes, Give 1945–1949 Year or Dates 1 ☐ Yes 2 📝 No Specify: Specify: 3 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Custodian School Systems permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arthur Frederick Buchin Charlotte Matilda Greenman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Buchin (Wife) 6024 Lucente Ave, Suitland, MD 20746 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lee Crematory May\_30, 2010 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexndria mo1555 Ferry Road, Clinton, MD 20735 moure 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Oneummia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical BB 26. Place of Death (Check only one) 1 Yes 2 **X**0 Other: Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) BOM 1ame 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

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31. Date filed (Month) PRYYO') 4 2010 32. Registra

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)

2. Registrar's Signature

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1. parks

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 26, 2010

State Registrar Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CO 05 0:40AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agomor oma Social Security Number 8. Date of Birth (Month, Day, Year) April 5 1945 **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Days Hours Country) Virginia 65 Director 578-56-1389 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Hyattsville Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7801 Barlowe Rd #319 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-00:6 2X No 1 ☐ Yes 2X No Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) the Legal Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mossette Matthews Dorothy Foxx 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Breta L. Francis / Daughter 3606 Dixon St. Temple Hills, Maryland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or Landover, MD. 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 6/4/2010 21. Signature of Funeral 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 nance Bladensburg Rd. Brentwood, MD Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed' death? 1 Yes Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗹 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year

JUN 03

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Ray Samuel Brandenburg, Jr. 5 P M 11 :3 JUNG 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 10 , 1 . Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral 1 ☑ M 2 □ F Months Hours Min. 217-12-2101 Director 86 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Smithsburg 10e. Street and Number 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral 14620 Tower Road 21783 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 *Gear Cutter* Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked Ray Samuel Brandenburg, Sr. Rae Hauver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Brandenburg (Wife) 14620 Tower Road Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State June 16, Smithsburg, Maryland Pleasant Valley injury 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee J.L. Davis Funeral Home 22. Name and Address of Facility MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con-equence of): Examiner neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day ed by the a detached for 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 호 2 200 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 🗌 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA this Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year, 06 2010 0063234

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

md

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6/01/2010 Year CHI FUNG CHENG 11:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 X F Days Min. 09/19/1920 Director 520-74-2373 89 China Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95 Dawson Avenue #715 20850 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Divorced 4 Divorced Completed Year or Dates Asian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Chung Kuang Chen Wen Huai Yen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kung Fu Cheng - husband 95 Dawson Avenue, #715, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 4 Donation 5 Other (Specify) 6/7/10 Silver Spring, MD 21. Si pature of Funeral Service Lice ree 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. 23a. Part 1. Enter Interval Between Onset and Death MONTHS Immediate Cause (Final Physician, Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠41≥ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to thrive 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 X No 2 **X**No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ᅆ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 🗌 Yes 28b. Time of Certificate: 28d. Describe how injury occurred XNatural 5 Pending (Month, Day, Year) in 24 hours after deau...
in Euneral Director: Aft 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 2 D0061887 6/1/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Avenue, Kensington, MD 20895 Ira Rabin 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		For State Of Wary  State Registrar		tificate of D			giene Reg. No.	) 1 0	18815		
Physicia	ın/	1. Decedent's Name (First, Middle, Last)			_	2. Date of Dea	Day	Year	3. Time of Death		
Medic Examin		Samuel Cohen  4a. Facility Name (if not institution, give street and number) 1801 East Jefferson Street #6	5/12	4b. City, Town, or Rockvill	Location of Death	June l		inty of Death	12 Noon <sup>M</sup>		
Funeral		5. Social Security Number 6. Sex 7. Age (In )	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Foreign			
Director		089-01-9139	Yrs.	Months Days	Hours Min.	01/30/1	y, Year) 1915	Сои	New York		
yland f show	tor	10a. State 10b. County 10c	. City, Town or Loc			-	_		10d. Inside City Limits		
With the Maryland 23a or 28a-f sho ust be notified at	Director	10e, Street and Number	Rockville	10f. Zip Code		Т	10g. Citizen	of What Co	1 🕅 Yes 2 □ No untry?		
ns 23a must b	Funeral	1801 East Jefferson Street #6		20852			Unite	ed Sta	ites		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ξ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar □ Yes 2 ሺ No	pecify Yes or No- b Rican, etc.) 14. Race - Ai Black, W Specify:						
Z15-UU36 in 72 hours after e. nan "natural", o	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give F	lent's Usual Occupa kind of work done d O NOT use retired)	uring most of work	ing	16b. Kind o	f Business I	siness Industry		
d withir dygiene ther tha	Be Co	Elementary/Seconday (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	Conti	racting Ó					vernment		
yland Ild be filed Mental Hy narked ott	TOE	Max Cohen			18. Mother's Nam Dora Sl	e (First, Middle, napiro	Maiden Surna	ìme)			
Mary 2 shoull th and h 27 is ma trauma		19a. Informant's Name/Relationship (Type, Print)  Charlene Cohen – wife		ng Address (Street a					Code) Le MD 20852		
Ore, of Heal of Heal if item ?		20a. Method of Disposition	b. Place of Dispo		!	Date	20c. Location				
Saltimore, bernit. Page 1 and Department of Hea mportant: If item any injury or othe		1 Donation 5 Other (Specify)  21. Signature of Fungral Service Licenses	Judean Me	em. Garde	ns 06/0	03/2010					
Deperment of the control of the cont	0 /	M0116	53 E	Name and Addres	el Funera Ville Pil	al Direck	tion N	<mark>Бс</mark> 208	352		
Pnysician/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line. Immediate Cause (Final						- 1	Approximate Interval Between Onset and Death		
Medical		disease or condition resulting in death)  a. Due to (or as a o	sequence of):	onllati	7/	4 1000		_			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	On/1977	04			$\rightarrow$			
ecuted and -transit	xami	cause, Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a con	sequence off:					$\rightarrow$			
se be ex ysician ne burial	dical E	d.									
os fou ertificate t iding physise as the b	√Meα	IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of	egnancy				234	Date of deli	iven		
DIVISION Of VITAI RECORDS, F.O. BOX 08/000 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 = of death 5 =	Ectopic pregnancy Other (specify)				Month	Day Year		
S, F.C. res that the signed by it doe detach	d by F	Part II. Other significant conditions contributing to death but no Dementia	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	_		the cause of death?		
iw requi	Completed by					24a. Was	an 24	b. Were aut	opsy findings available completion of cause of		
VITAI MECOTAS, vsician: The law requires is certificate has been sig		25. Was case referred to medical				perfo	rmed? 2 No	death?	2 No		
VITAI nysiciar nis certif	To Be	examiner? Hospital;	2 ☐ ER/Outpatien	Otho	ce of Death (Chec r: 4 \square Nursing Ho		lence 6 🗆 0	Other (Speci	fy)		
In OT Iding Pl th. After the funeral	cate:	27. Manner of Death  Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Yea	r) 28b. Time of injury	28c. Injury work? M 1 🗆		28d. Describe h	ow injury occ	urred			
DIVISION OI al or Attending PI s after death. Il Director: After the	Certificate:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow		nber or Run	al Route Number,		
Hospit 24 hour Funera sted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiner)	ation and/or invest	igation, in my opinio	n, death occurred a	t the time, date a	nd place, and	due to the c	ause(s) and manner stated.		
	Σ	only one) 3 Certifying Nurse Practioner: To the best of Certifying Nurse Practioner: To the best of Certifier	or my knowledge, d	29c. License	number		29d. Date sig				
12		30. Name and address of person who completed cause of death	MD (Stem 22a) (Stem 5)	l D O	0693 Rockvil	68	June	2, 2	.010		
		A. Chilakamarn 6/21	montos	se Rd	Rockvil	le, M	D				
Stat Registra		31. Date filed (Month, Day, Year)	gnature	the .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sister M. Assumpta Anna Conti JUNE 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14259 Benedictine Lane Ridgely Caroline 5. Social Security Number 8. Date of Birth (Month, Day, May 17, 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 1 ☐ M 2 🛣 F 93 221-42-3094 1917 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a majoral Examinar must be notified at Director 1 ☐ Yes 2 X No Caroline Maryland Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14259 Benedictine Lane 21660 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sister of St. Benedict Religious 5+17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Michael Conti Assunta DiRienzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau Sr. Catherine Higley/ Prioress 14259 Benedictine Lane; Ridgely, Maryland \_21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State St. Gertrude's Cem 4 □ Donation 5 □ Other (Specify) June 9, 2010 Ridgely, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die o (or as a consequence of): Examiner Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? CARDIAC FAILURE ONGESTIVE 2 No 1 ☐ Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \(\mathbb{B}\) Residence 6 Other (Specity) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a, Certifier 🖭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

الباريري المجادر كالباريري المراكبة المراكبة المراكبة Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The within 24 hours after deatl To the Funeral Director: completely filled in by the

Maryland

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

DHMH 17 Rev 1/2001

WIL

10 1A

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

21157 Robert

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death May 25, Physician 2010 William Russell Clow, Sr. 8:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Carroll 207 St. Matthew Ct., #508 Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day Year) 1929 NJ 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 15€M 2□ F 80 Yrs. 212-28-1959 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours aftar deeth with the Maryland pegestant of Heelih end Mentel Hygiene.
Important: If them 27 is marked other than "neture!" and injury or other treumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11\$ Yes 2 □ No Funeral Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 207 St. Matthew Ct., #508 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 195 If Yes, Give Year or Dates: 195 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1951 1 Never Married 2 Married 1 ☐ Yes 2 ➡ No Specify. Specify: White É 1953 3 ∑Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Frederick Co. Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Raymond Clow Eva L. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19A E. 4th St., Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print)
William Clow, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cremations, Inc. 5/26/10 Hampstead, MD Carroll 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityPritts Funeral Home & Chapel PA 21. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, MD 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner attanding physicien and I for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vitai Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown é 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Y69 2 N Director: After this cartific d in by the funerel director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 ☐ Nateral 2 ☐ Accident 5 Pending 1 Yes 2 No eftar daath. investigation 6 ☐ Could not be determined within 24 hours effar day To the Funeral Director completaly filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Principle Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Exami ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State MAY 2 6 2010 Registrar

DHMH 16 Rev 6/95

Box 68760. P.O. Division of Vital Records, death.

the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Arector of completely filled in by the fi within 24 hours

To the Funeral

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of Cartified

29c. License number D0067788 29d. Date signed (Month, Day, Year) 5.28.2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 CENA RAO KODALT

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

JUN 0 3 2010

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 30. 2010 THERESE L. CAYARD 8:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES ACCOKEEK RESIDENCE. 103 MATTAWOMAN WAY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours AUGUST 27, 1935 062-48-6287 74 HATTY **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ACCOKEEK 1 X Yes 2 No MARYLAND PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 1 and 2 should be filed within 72 hours after death with the if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 103 MATTAWOMAN WAY 20607 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Yes 2 XNo þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+)
YEARS Elementary/Seconday (0-12) HOME HEALTH AIDE HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CONSTANT LEGROS FARILIA DERIVAL LEGROS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 MATTAWOMAN WAY, ACCOKEEK, MARYLAND REGINA BETHEA / DAUGHTER 20607 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot St. Mary's Catholic Chu JUNE 4,2010 Piscataway, Clinton MD 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fune - Service ON FILLERAL HOME, P. A. LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 INDIA C. THORNTON JOHNSON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached for Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Thinknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 24 No this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🔀 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 
Yes Certificate: 28d. Describe how injury occurred After 1 🗶 Natural 5 Pending injury after death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2  $\square$  No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examine 3 [ Cerp only one) 29b. Signature ag Name and address use of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

MUUL

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Ferguson Cosimano May 28, 2010 10:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours July 15, 1924 Maryland Director 85 579-92-2112 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3146 Gracefield Rd FR111 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Clare Quaid George Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 Kent Oaks Way, Gaithersburg, MD 20878 Kevin Cosimano/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate Of Heaven Cem June 3, 2010 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagli line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Box in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗓 No 9 ☐ Unknown 4 ☐ Pregnant 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \bar{X} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of
injury
28c. မ 28c. Injury at 27. Manner of Death Certificate: 28d. Describe how injury occurred 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

23

OSIMANO;

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Contreras 22:52 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore Universit 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Months Hours Min. none 37 A 8 1 1 1 1 1 1 1 1 1 9 7 3 Mexico Director Usual Residence of Decedent 28a-f show raf", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director Md Baltimore Reisterstown 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 21136 10g. Citizen of What Country? 434 Shirley Manor Road Mexico 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 White 1 ☑ Yes 2 ☐ No Specify: Mexican "natural" 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angela Gonzalez Hernandez Jose Luis Arcos Santos 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Juan Manuel Contreras/ 434 Shirley Manor Road Reisterstown, Md Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Chilpancingo Department of 1 X Burial 2 Cremation 3 Agemoval from State remetery, crematory or other place)
Panteon Municipal
Chilpancingo 6/12/2010 Guerrero, Mexíco 4 Donation 5 Other (Spec 21. Sign 1 PHTETPAODS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Stage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner caholic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown the a detached 9 Unknown P.0. ģ signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, To the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Matural 5 Pending injury Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Mofith, Day, Year)

Greene

Sto, Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 3:36 a Month Year Robert Goskirk Carnahan May 31 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Mon top mery Social Security Numbe 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) C. **Funeral** 8. Date of Birth 1 X M 2 D F Months Days Min 579-09-1509 Nov. 1914 95 **Director** Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Montgomery 1 🗌 Yes 2 🎦 No Silver Spring 10e. Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 15401 Bassett Lane, Apt. 10 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iter Examiner 14. Race - American Indian. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 Divorced Year or Dates. the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Lobbyist F.A.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o e 1 and 2 should be fill of Health and Mental If item 27 is marked or မှ Robert Carnahan Margaret Goskirk 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15401 Bassett Lane, Apt. 1C, Silver Spring, MD 20906 Carol Knapstein Carnahan/Wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State August 30 2010 30 4 Donation 5 Other (Specify) Arlington, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between shock. Immediate Cause (Final Onset and Death Physician/ stina gastroint disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ig physician and as the burial-transit Va VUL that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 ☐ Yes 2 🖾 No Other: 1 🛱 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Matural Natural 5 Pending work?
1 Yes n 24 hours after death. le Funeral Director: Ai pleted filled in by the fu 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complet 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) MI 104 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aruna Paspula, MD 18111 Prince Philip Drive, Olney, MD 20832

State

Registrar

31. Date filed (Month, Day, Year)

02

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Susan Perper Chapman Marth 24<sup>y</sup>. 20TO 04:58A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours DCT onth 164, Ye 1944 527-84-4229 65 Olff (Btry) Director Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 12 Brighton Court 20877 United States of America items hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. 1 Never Married 2 Married ò 5 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Operations Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lloyd Perper Sally Bowman and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> permit. Page 1 and 2 st Department of Health a Important: If item 27 is Alexander Kenyon Chapman. Spouse 12 Brighton Court, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. injury or 1 Burial 2 XCremation 3 Removal from State Ft Lincoln Crematory 05/29/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Coronary Arterial Disease **Medical** Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Examil Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Lymphocytic Leukemia tran that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No ģ Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been signe page 2 should be o 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 🗶 No Yes 2 No npleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury **A**latural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signati 29c. License number 29d, Date signed (Month, Day, Year) D35635 May 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr. Joseph Kaplan. MD Olney, MD 20832

State

Registrar

JUN 01

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29, Physician/ 3:15am Elizabeth Flehinger Chambre' 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 15107 Interlachen Drive, Apt. #721 Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Germany 1 □ M 2 🛛 F 10/05/1919 Hours Director 90 216-16-5014 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic account. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Montgomery Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 15107 Interlachen Drive, Apt. #721 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 Married þ Yes 2 X No 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Therapist Medical Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Isaac Flehinger Marta Stoessel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark W. Chambre' - Son 13900 Zeigler Way, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) David Mem. Grdns 05/30/2010 | Falls Church. VA 21. Signature of Funeral Service License Ho #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Condition Physician/ Respiratory Failure Medical resulting in death) Examiner Non-Hodgkins Lymphoma 11 years Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year g 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Colon Cancer 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an autopsy performed? Yes 2 K No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burla-transit Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Ballating, stat (Spearly)	O.A.	ty of Town, Glate)
29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, death occurrence only one)  1 M Certifying Physician: To the best of my knowledge, death occurrence only one)  2 Medical Examiner: On the basis of examination and/or investigation only one)	n, in my opinion, death occurred at the time	ne, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
fund M Jumel ma	D35996	May 29, 2010
of the state of th		

**JUN 01** 

Medical

Linda M. Burrell, MD,

2730 University Blvd., #400, Wheaton, Maryland 20902 31. Date filed (Month, Day, Year)

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2, 2010 8:45A Martha Cecelia Cross 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Oxon Hill Elkhart Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) 1 M 2 X F 89 1/27/127/1920 Washington, DC 579-14-0039 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Marvland Prince George Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 **USA** 1003 Elkhart Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Hutchinson Dorothy Beal1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard J. Cross/ Husband 1003 Elkhart Street, Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 6/3/2010 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 23a. Part 1. Enter the diseale, or complication, that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

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10a. State

Directo

Funeral

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Completed

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21. Signatur

**Examiner** 

**Funeral** 

**Director** 

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

al Hygiene. I other than "

should be file and Mental F is marked of

traumatic event,

within 72 hours after death

Baltimore, Maryland 21215-0036

burial-transit Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death.

	Conventially list conditions	h							
alling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events	Due to (or as a consequence	of):						
}	resulting in death) Last	Due to (or as a consequence	of):						
		d							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 ANo g □ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal deat 4  Pregnant at time of death 9  Unknown	h 3 🗆 Ector 5 🗆 Othe	oic pregnancy r (specify)			23d. Date of de Month	livery Day Year	
	Part II. Other significant conditions of	-	-	ng cause given in Part I.	23e. D	id tobacco	use contribute to	the cause of death?	
3	Atherosclerotic	Cardiovascular D	isease		1	☐ Yes 2	□ No 3 □ P	robably 4 🕅 Unknown	
	Diabetes Mellitu	ıs				Vas an	24b. Were au	topsy findings available completion of cause of	
5	Hypertension, Co	ongestive Heart Fa	ailure		l p	erformed? res 2 🔼 N	death?	s 2 No	
	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)				
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient_3 [	DOA Other: 4 \( \sum \) Nursing H	lome 5 🗓 F	Residence_	6 Other (Spec	cify)	
ווכפובי	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Descri	be how inju	ry occurred		
	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medica	(Check 2 Medical Exam	sician: To the best of my knowledge, iner: On the basis of examination and/ se Practioner: To the best of my know	or investigation	, in my opinion, death occurred	at the time, da	ate and place	e, and due to the	cause(s) and manner stated.	
-	29b. Signature and title of cortifier			29c. License number			ate signed (Month		
	> hus			D53782		Jun	e 2, 20	10	

11701 Livingston Rd. #101 Ft. Washington, MD 20744

Registrar

**State** 

31. Date filed (Month, Day, Year) JUN 0 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Verghese, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 26 20 Î d Domingo Ceballos 4:45p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Chevy Chase Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** onth, Day, 1 Months Days 577-42-6144 Director 93 1917Dominican Republic Usual Residence of Decedent works, filled within 72 now, our tall Hygiene.
ed other than "natural", or items 23a or 28a-f showed other than "natural", or items 23a or 28a-f showed other than "natural". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2567 Markham Lane United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Dominican If Yes, Give Year or Dates Specify: Dominican 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th Chauffeur Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Armando Riva Maria Ceballos injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important; If item 27 is
any injury or other fram Mario Rodriguez/ Grandson 2567 Markham Lane Hyattsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery | 06/01/2010 | 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 Part . Enter the disease r co shock, or heart failure. List only clications that is used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 100 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 124 hours after death. 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sero, mo 20057124 5/28/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD 9715 Medical Center Drive Suite 201 Rockville, MD 20850 32. Registar's Sign State JUN 0 3 2010

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Records,

Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carol L. Campbel1 May Medical 2010 3:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕅 F Days 3-2-1929 Months Hours Min. West V<mark>irginia</mark> Director 577-34-1374 Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Forestville Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funera 2801 East Avenue 20747 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 2 1 Never Married 2 Married 1 Yes If Yes, Give hours after 1 Yes 2X No Specify: WHITE "natural" Completed 3 X Widowed 4 □ Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 ulth and Mental Hygie
27 is marked other
r traumatic event, tf <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important. If item 27 is marked or မ Daniel Henry Maymie Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard L. Campbell (Son) 11202 Hickory Grove Ct. Laurel, MD 20708 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 6/7/2010 Brentwood, MD 21. Signature of Funeral Spice Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home what 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence o -transit and that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Day Month signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 24 No De 25. Was case ref to medical 1 Yes 2 No æ 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 eral Director: After this certificate filled in by the funeral director, page within 24 hours a

Accident

29b. Signature and title of certifie

JUN 0 3 2010

□ Acciden
 □ Suicide

☐ Homicide

29a Certifier

(Check

Maryland 21215-0036

Baltimore,

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kou

Investigation

determined

6 Could not be

446

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Medical

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

> 24020

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Year** Alvin Douglass 2010 8:45a M May 26, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgo mery Silver Spring Fox Chase Rehab & nursing | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-10-2275 1 🔀 M 2 🗆 F 98 Yrs. Director Washington DC 25, 1912 Mar. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Funeral Director Washington item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified DC N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20011 1981 Upshur Street, NW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2XXNc Baltimore, Maryland 21215-0036 Specify: Colored 1 ☐ Yes 2XX No Specify: Yes. Give 3 🔀 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) U.S. Post Office U.S. Postal Manager and 2 should be filed with Health and Mental Hygien iem 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Johnson Douglass Marie Lockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin G. Douglass, Jr. / son 3025 Ontario Road, #104, NW, Washington DC 20009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 6/4/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Avenue, NW, Washington DC 20012 Mio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Euheral Director: After this certificate has been signed by the attending physician and ared filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Pressure Ulcer Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗷 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067092 May 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Suite #130, Rockville, MD 20850 Weihan Wang, M.D. 31. Date filed ( 3 2010 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE 9:25PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. West Virginia 117/12/19/22 577-26-6570 87 Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County 10a, State within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e, Street and Number 5 10f. Zip Code 10g. Citizen of What Country? USA ral", or items 23a or Examiner must be Funeral 21401 843 Singing Hills Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruby Wright Hollis Kemper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Frank J. DeGeorge/ Husband 843 Singing Hills Court, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 6/1/10 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ END STABE HEART disease or condition resulting in death) Medical **Examiner** eavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of and I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ng physician ar as the burial-t Due to (or as a consequence of Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign d be 1 Yes 2 No 3 Probably 4 Unknown Completed ATRIAL FIBRILLATION 24a. Was an 24b. Were autopsy findings available has autopsy performed? prior to completion of cause of death?

1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) MANDRIA 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one 29b. Signatur Q State

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security No. 070–12–42	284	Sex 1 M 2 D F 88	ge (In yrs. la:	st <i>birtha</i> Yr	Months Days		Hrs. 8. Date of B Min. 6/29/		g. Birthplace (State or Foreign Country) New York	
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H 5+	\	30 Name and addre	ess of penson wh	o competed cause of a	death (Item :	23a) (Ty	DEYENSE	Hisi	+ WAY AN	NAP	POLIS M	n 2401
Stat Registra		31. Date filed (Month	h, Day, Year) JUN 01	2010 32. Pégistr	rar's Signatu	d.	park					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death May 30, 2010 Physician/ Broughton Dobyns 5:30 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Necitas Assisted Living Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Country) D.C. Days 1 🛛 M 2 🗆 F Hours Min. oct. 7, 1926 Director 579-26-5540 83 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Columbia Maryland Howard 1 Tes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21044 USA 5125 Harpers Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces' Completed by Page 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene, ant: If Item 27 is marked other than "natural", or 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: White Specify: WWTT era 3 🖵 Widowed 4 🗆 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Collega (1-4 or 5+) Automotive Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Erma Lewis ည Eugene Elliott Dobyns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5125 Harpers Farm Road, Columbia, MD 21044 Thomas Dobyns/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery June 4, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Immediate Cause (Final Aspiration Pneumonia Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Parkinson's Disease vears Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Hypertension vears the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Sepsis 2 days Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Hypercholesterolemia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?

1 Yes 2 No Assisted Living Other: 4 Nursing Home 5 Residence 6X မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 [ 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D45784 June 1, 2010

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addr

31. Date filed (Month, Day, Year)

JUN 03

ess of person who completed cause of death (Item 23a) Type, Print) Nieroda, Md 7350 van Dusen Road, #320, Laurel, MD 20707

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rose Mary DeSimone May 27. 2010 7:26 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 Days Months 577-32-7996 82 Hours June 11, Year 927 Country) Director Yrs D.C. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 1001 Spring Street, Apt. 315 20910 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Divorced Specify. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph DeSimone, Sr. Rosa DiNenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina D. Spangler/Niece 516 Stonington Road, Silver Spring, MD 20902 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State May 28 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, VA . Sign rure of Funerவி 22. Name and Address of Facility Francis J. Coll 500 University lins Funeral Home Inc Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Multiple Myeloma yrs. Medical resulting in death) Due to (or as a consequence of) Examiner Renal Failure mos. Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Myocardial Infarction wks. attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 ☐ Yes 2 🔀 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury the Funeral Director: After After funeral filled in by the funeral fill 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 2 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

D 0065 485

1500 Forest Glen Road, Silver Spring, MD 20910

27/2010

Supanich

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Barbara Supanich, MD

31. Date filed (Month, Day, Year)

JUN 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month 29 2010 рм Edward L. Fuller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **XX**M 2 □ F Days Hours (Month, Day, Year 83<sub>Yrs</sub> 543-14-9669 Director 0regon 1926 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tyes 2 No Mayo Maryland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Likes Road USA 21106 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes. Give rryes, Give Year or Dates. 1942–46 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday onday (0-12) College (1-4 or 5+) Self Employed Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id be file Mental I ည Lona M. Powers Edward L. Fuller t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Likes Road, Mayo, Maryland 21106 Anna Fuller / Wife permit. Page 1 and 2 Department of Health Important: If item 2: any Injury or other t Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 5-31-2010 4 ☐ Donation ☐ Other (Specify) Edgewater, Maryland 21. Signature of Fulleral Se 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Enter the disease, or complications that caused the death. Do not enter ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 140 Inpatient 2 ER/Outpatient 3 DOA 욘 After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending ☐ Natural r death. 1 Tes 2 No Accident Investigation within 24 hours after deal To the Funeral Director 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioners To the best of my knowledge, death occurred at the time, dath and plane, and due to the cause(k) and manner as state. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 3 y 30. Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month J Frazee Tracy 9.05 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Cente Anne Arundel Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F South Carolina Months Days Hours Min (Month, Day, Year) Director 220-72-7884 46 08/26 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Anne Arundel Maryland Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1043 Omar Drive 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 ☐ Never Married 2 💹 Married Completed by ☐ Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 9th <u>Superintendent</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donovan Byron Frazee, Jr. Janie M. Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trelana M. Frazee/ Wife 1043 Omar Drive, Crownsville. MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Kalas Crematory 6/1/10 Edgewater, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home Mulles 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Stage disease or condition resulting in death) INCr Medical Due to (or as a cons collence of): Examiner atitis Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate flas been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

Hospital 31. Date filed (Month, Day, Year) JUN 0 1 2010

ADEGBULUEBE ANGELAM.

Drive

Glan Burnic, MD 20161 Degistrar's Signature

NAZLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEGBULUEBE ANGELA

29c. License number

D6069727

29d. Date signed (Month, Day, Year)

05/30/2010.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII per MD G905 7/1/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:50 P 2. Date of Death Physician/ June 1, 2010 Anna FRIEDMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Montgomery Hospice Casey House 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F Days Hours Min. <sup>rear)</sup>1910 NewYork Director 99 101-10-9931 Usual Residence of Decedent or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Directo Silver Spring Maryland Montgomery 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15211 Elkridge Way #2B Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify. pernit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sonya Snyder Meyer Nash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2556 Rellim Road #D, Baltimore, MD 21209 19a. Informant's Name/Relationship (Type, Print) Sonia Friedman, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 06/02/2010cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) David Memorial Garden Falls Church, VA 21. Signature of Pa Torchinsky Hebrew Funeral Home Carroll St., NW. Washington, DC 20012 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, E Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Lymphoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and I-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail according Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? Septicemia 24a. Was an autopsy 1 ☐ Yes 2 😾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: As completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title, of certifier 29d. Date signed (Month, Day, Year) 1600 altchou, 263748 Jocetyne June 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) 72. Registrar's Signature State 3 JUN 0 Registrar

68760

Box

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24. 2010 Alan Gelberg 19:02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month Day, Year 28 1**X** M 2 □ F Months Days Hours Min. 056-20-8846 New York Director 81 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director items 23a or 28a-f 1 🖾 Yes 2 🗆 No MD Chevy Chase Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? by Funeral 8100 Connecticut Avenue #1511 20815 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 No 1953 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist F.D.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Moses Gelberg Sarah Chanin Department of Health and Men Important: If item 27 Is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitty Gelberg/Daughter 153 Union Avenue, Saratoga Springs, New York 12886 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State cemetery, crematory or other place) King David Mem. Grds. 5/28/2010 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Danzansky-Goldberg Memorial Chapels, Inc. Melissa Greenhut 4(Greening 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Amyloidosis Unknown disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Syncope 5/22/2010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) End Stage Renal Disease the burial-transi Cause (Disease or iinjury that initiated events Unknown Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for 5 Other (specify) Pregnant at time of death Year 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 v No ☐ Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 🔀 No Other: ပ 4 Nursin Home 5 Residence 6 Other Specify 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifications.

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0062999 May 25, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **JUN 0 4** 2010

Fedele Dames, M.D. 11500 Old Georgetown Road, Rockville, Maryland 20852

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 3ªy Ma y 2010 Majorie Queen Gibson 1945 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Center Anne Arundel Anne Arundel Medical Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Min. 220-22-5952 J(1991th, 2019, 19921 Mary land 89 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Iral", or items 23a or Examiner must be Funeral 1807 Lincoln Dr. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ed other than "natural", event, the Medical Exal Specify: Black 3

▼ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>12t</u>h Admin<u>istrative Assistant</u> Head Start 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Nathaniel Queen Aldora Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jolence Jones (Daughter) 919 West Ave H Kingsville, Tx78363 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran : 6-1-10 MMame Ranseof ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Examir The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by th, funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1. Natural 5 Pending 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only of 29c. License number 29b. Signat 29d. Date signed (Month, Day, Year) D16376 of death (Item 23a) (Type, Print) 30. Name and a

Registrar
DHMH 17 Rev 7/2009

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10f. Zip Code

20837

10d. Inside City Limits 1 X Yes 2 ☐ No

10g. Citizen of What Country?

**USA** 

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 05/28/2018 Year EVELYN LUCILLE GRAHAM 11:42 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Days 02/28/1922 577-58-9531 88 MD

10c. City, Town or Location

Poolesville

**Examiner Funeral** Director

Usual Residence of Decedent

10e. Street and Number

Montgomery

19425 Jerusalem Road

10a. State

MD

neral Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified as Baltimore, Maryland 21215-0036 Physician/

Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

y F	11. Marital Status  1  Never Married 2  Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 24 No	If Yes, specify Cuba	ispanic Origin? (Specify ) ın, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, Whit	
Be Completed by Fu	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No	Specify:		Specify: B1	ack
plet	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occup (Give kind of work done		16b. I	Kind of Business	Industry
Som	Elementary/Seconday (0-12) 8th	College (1-4 or 5+)	ife. DO NOT use retired)  Domestic Worke			Home	
Be (	17. Father's Name (First, Middle, Last)		DARESCIC WOLK	18. Mother's Name (Firs			
ပ	Eugene Wims			Martha Doi		Gamanoy	
	19a. Informant's Name/Relationship (Ty Angela Graham El		19b. Mailing Address (Street 18911 Perrone				' I
	20a. Method of Disposition		lace of Disposition (Name of	Date		ocation - City or	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	Removal from State	emetery, crematory or other place at UMC Cemete	e)		olesvill	
	21. Signature Funeral Service Licens		- /	ss of Facility Snow	1		•
	Hunge	Arrand		shington St			
	23a. Part 1. Enter the diseas or comp shock, or heart failure. Ust only or	olications that caused the death ne couse on each line.	n. Do not enter the mode of dyin	g, such as cardiac or res	piratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Breast Cand	cer				Onset and Death
	resulting in death)	Due to (or as a conseque	ence of):				
Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):				
amir	cause. Enter Underlying		,				
I Ex	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
dica		d					
/Me	IF FEMALE:	OZa lfuga autoama af prancas					
cian	in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3 🗌 Ectopic pregnand	÷y	1	23d. Date of de Month	livery Day Year
Completed by Physician/Medical Examiner	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	9 Unknown	outil o in other (openity)				
y P	Part II. Other significant conditions co	entributing to death but not resu	ulting in the underlying cause given	ren in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ted					1 🗌 Yes 2	□ No 3 □ P	robably 4X Unknown
ple					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Con					performed?  1  Yes 2 N	death?	s 2 🗆 No
Be	25. Was case referred to medical examiner?	Hospital:		ace of Death (Check only	one)		
2	1 ☐ Yes 2 ☒ No	1  Inpatient 2 E	ER/Outpatient 3 DOA Other	4 L Nursing Home			ify) Hospice
ertificate: To	1X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury work		Describe how injur	ry occurred	
rtifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon	ne, farm, street, factory, office	28f. L			ral Route Number,
	200011111100	building, etc. (Specify)			City or Town, State	e)	
Medical C	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investigation, in my opinio	n, death occurred at the ti	ime, date and place	e, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier		29c. License	number		ite signed (Month	
	Dune	Ruckert (	CRAP RII	5108		5/30/10	
	30. Name and address of person who co			orille MD 1	20855		

State Registrar

31. Date filed (Month, Day, Year) **JUN 0 3 2010** 

backer

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Etta Marie Gross 240 27,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SalisburyRehabilitation+NursingCtr Wicomico 8. Date of Birth Month Day Year) 10/11/1915 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🛣 F Days 214-32-0722 Virginia Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modell Examinal must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 Civic Ave. 21804 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinar in ust any injury or other traumatic event, the Medical Examinar in ust once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No white Specify. Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall James Miller Katherine Dorothy Miller 19a. Informant's Name/Relationship (Type. Print)
Ralph D. Richardson/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27357 Fairmount Rd., Westover, MD 21871 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/3/2010 Hebron, MD Signature of Fungiral Se Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 arre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician an-/Medical Due to (or as a consequence of) Examiner 700am Sequentially list conditions, it any, sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins, M. D

Registrar's Signature

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month <sup>Day</sup> 2010 Year **Physician** 23, 8:42 A M Mark Anthony Gelwicks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 218-50-2867 59 17, **Director** Oct 1950 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 XYes 2 □ No Frederick Emmitsburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3205 Stonehurst Court 21727 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: \$ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Register of Wills permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item any Injury or other traumatic event, If Item and Item Elementary/Secondary (0-12) College (1-4or 5+) **5 +** Chief Deputy Frederick County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Earle Robert Gelwicks Donaldine Hann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa A. Gelwicks, wife 3205 Stonehurst Ct, Emmitsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cem 5/27/2010 Frederick, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License R. 1 St. Emmitsburg, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performer certificate 1 ☐ Yes 2 🔼 No 2 🗆 No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

Division of Vital Records, 24 hours after deat Funeral Director: ပ

Baltimore, Maryland 21215-0036

Box 68760

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completely within 2 To the WJL 12

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

Everett T. Hart MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

and manner stated.

75 Thomas Johnson Dr. Ste B Frederick, MD 21702

MAY 26

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0044237

29d. Date signed (Month, Day, Year)

5/24/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For	State o	of Marylar					and M	lental Hyg	iene	nin	1001.2
			State Registrar	( oot)		Cer	tificate	of D	eath			eg. No.	UIU	10042
	siciar		1. Decedent's Name (First, Middle	,							2. Date of Deat Month May 30	Day	O Year	3. Time of Death 5:26 P M
	ledica amine		Juanita M. Genda. Facility Name (if not institution,		nber)		4b. City, To	own, or l	Location o	of Death	May 30	1	unty of Deat	
	4111111		Shady Grove Ad			L		ckvi					tgome	
Fund			5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	-	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Birth	Year)	9. Birt	thplace (State or Foreign
Direc	ctor		579-04-8256 Usual Residence of Decedent	I 🗆 IVI Z 🧛 I	82	Yrs.			110010		02/08/1	928	Phi	lippines
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a or 2	pe ud		10e. Street and Number				10f. Zip C	Code			1	0g. Citizen	of What Co	untry?
h with	must	Funeral Director	14704 Quince 0					2087				Unit	ed St	ates
r deat	iner		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marr</li></ul>	Armed Fo			Vas Deceder f Yes, specify	nt of His y Cuban	panic Orig , Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.
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Wary 2 should th and M 27 is mai	E I	1	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (S	Street ar	nd Numbe	r or Rura	I Route Number,	City or Tow	n, State, Zip	Code)
ire, Maryland Z1Z13-UU30 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show			Francisco M. G	enegaban	(Son)	1470	4 Quir	nce (	Orcha	ard I	Road Nor	th Po	tomac	, MD. 20878
Ore, ye 1 and t of Hea	#		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from		Place of Dispo cemetery, cren	sition (Name natory or oth	e of er place	)	June		20c. Locati	on - City or	Town, State
baltimor	Ž I		4 Donation 5 Other (S		A11	Souls				20	10			, Maryland
baltimore, Mispermit. Page 1 and 2 st Department of Health a Important: If item 27 is	any ir	1	21. Signature of Funeral Service L	TU June 1	Mour						ol Funer			, MD. 20877
		┪	23a. Part 1. Enter the disease, or	complications that	aused the dea								SDUIS	Approximate
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LAdiii	_	<u>ا</u> ۾	Sequentially list conditions,	0.	umonia	MATERIAL STATE								
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death ce	Sn Jo	cian,	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No		come of pregn Birth 2  Fet nant at time of	al death 3	Ectopic pro					23d.	Date of del Month	ivery Day Year
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or Attendir fter death. lirector: Af	n ka l	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nad 28e. Place	of Injury - At h ng, etc. (Specif		eet, factory, o	office			28f. Location (Str City or Town		mber or Rui	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed find in the table formed director.			29a. Certifier 1 X Certifying	Physician: To the b	est of my know	vledge death	occured at th	ne time (	date and r	nlace and	d due to the caus	se(s) and m	anner as sta	ited
n 24 h	Delleic	Medical	(Check 2 Medical E		is of examination	on and/or invest	igation, in my	y opinion	, death oc	curred at	the time, date and	d place, and	due to the	cause(s) and manner stated.
			29b. Signature and title of certifier	/			29c. l	License i	number		2	9d. Date si	gned (Month	n, Day, Year)
2			1 Daute	WA				001	245	202		June	01,	2010
_			30. Name and address of person v Brian Anthony					Can	ter T	Driv	e Rockvi	11e.	Marv1	and 20850
	State	,	31. Date filed (Month, Day, Year)	₿2. R				7611		v '				
Reg	jistra		JUN 02 20	110 Pend	egistrar's Sign	park	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ella Elizabeth Gross Medical May 30 10:10 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Clinton Southern Maryland Hospital Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 214 52 7438 Hours Min. 62 Mary Land Director March Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Prince George's Fort Washington 1 Yes 2 Tho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8005 Veltri Drive 20744 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced **Black** the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supply Tech Federal Government permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Cutchember (Daughter) 8005 Veltri Drive, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Lee Crematory June 5, 2010 Clinton, Maryland 21. Signature of Funeral Service Licensee mols 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical <sup>/</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine es a consecuence of that the death certificate be executed Due to (or as a consequence of): anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) hed by the atter detached for u in the past 12 months? Month Day Pregnant at time of death Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 24 hours after death, Funeral Director: After this certificate has been signeted filled in by the funeral director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No Endme cinom) Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 1988 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 55 - 7 200 SOUTHERN Bolello 1328 D

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Registrar's Signature

10-04424 Gerald Grill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erald Grill	1- For State	e of Maryland	Departme Certifica			Mental Hy		Reg. No.	0 18814
Physician/ ledical Examine	Registrar  1. Decedent's Name (First, Middle,La	ld Paul (					2. Date of Dea Month June 10,	ath Day Year	3. Time of Death 2126 hrs
	4a. Facility Name (if not institution, g Johns Hopkins Hospital			45	. City, Town, or L Baltimore	ocation of Death	ound to,	4c. County of I	Death
Funeral Director	5. Social Security Number 6. 8 185-22-4310 15	Sex 7. Ag	e (In yrs. last birtho	day) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.			B. Birthplace (State or foreign Country) PA
Maryland 28a-f show any <u>d at once.</u> ector	Usual Residence of Decedent  10a. State 10b. County  PA Lanca		10c. City, Town or		1	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 1.23a or 28a-f shov notified at once. al Director	10e. Street and Number 243 Spring G	arden St	reet		10f. Zip Code	2		10g. Citizen of What $U \bullet S$	
fter death w !", or items er must be / Funer	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent	Ever in U.S.	If Yes	Decedent of Hisp , specify Cuban, fes 2 X No	anic Origin? ( Sp Mexican, Puerto			American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine To Be Completed by	45 Decedent's Education (Consider		npleted) 16a. De du 5+)	uring mos	Usual Occupation to of working life. [	OO NOT use retir	red)	16b. Kind of Busin	ess/Industry
21215-0036 und be filed within 72 Mental Hygiene. marked other than ic event, the Medical To Be Comple	James A. Gri	it)	<b>-</b>		18	3.Mother's Name Laura	(First, Middle,	Maiden Surname)	
and 2 should lealth and Mc tem 27 is ma traumatic c	19a. Informant's Name/Relationship (Shirley E. G	rill / Wi	.fe 20b. Place of	243 Dispositi	Spring	g Garde		Ephrata  20c. Location - C	a, PA 17522
Baltimore, oemit. Pages 1 ar Department of Hee Important: If iten injuryer other tr	1 Burial 2 Cremation 3 4 Donation 5 Other Specif 21. Signature Cruneral Service Life	y: .		s Cr	emator	y   2	ne 13, 010	Leo	la, PA
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/Medical Examiner	failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	each line. <u>Hyperten</u> Due to (or as a conse		eros	cleortic	cardio	ascula/	r disease	Between Onset and Death
aminer	Sequentially list conditions, if any license immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consection)  Due to (or as a consection)							
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box 68760, the death certificate by the attending physiched for use as the bur Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcom 1 Live birth 4 Pregnant at	ne of pregnancy time of death  5	Feta	death 3 r	Ectopic pregna	ncy	23d. Date of de Month	Nivery Pear
ires that the de signed by the detected:	Part II. Other significant conditions Liver cirrhosi	-	_			ven in Part I.			te to the cause of death?  Probably 4  Unknown
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n of Vital Recing Physician: The land After this certificate funeral director, page on: To Be Con	27. Manner of Death	Hospital: 1 Inpatie	ry 28b. Ti	patient me of Inji	3 DOA C	- Lannard	g Home 5	Residence 6 how injury occurred	Other:
ti he sa be o	1 X Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no determin	ot be 28e. Place of In	jury - At home, farr	m, street,		es 2 No ilding, etc.	28f. Location or Town,		or Rural Route Number, City
Divisi  To the Hospital or An within 24 hours after de To the Funeral Direct completely filled in by ledical Certifical Certifical	one) 2 Medical Examin	cian: To the best of m er:On the basis of exam and manner stated.	y knowledge, deatl mination and/or inv	h occurre restigatio	n, in my opinion,	death occurred a	due to the cau	e and place, and due	to the cause(s)
<b>D</b>	29b. Signature and title of certifier  30. Name and address of person who	2 Completed cause of d	eath (Item/3a)		29c. License O.C.M			June 11, 201	(Month, Day, Year)
State	Zabiullah Ali, M.D. Ass	sistant Medical Ex		Penn	Street, Baltin	nore, MD 21	201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Francis Anthony Holbrook May 27 2010 10:05 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Long View Nursing Home Carroll County Manchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 220-09-0599 1919 Maryland 25, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll County 1 ☐ Yes 2 🎇 No Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2917 Hanover Pike 21102 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2□No 1943-1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 👿 No Specify: 1945 white Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bricklayer construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph M. Holbrook Mary S. Greenwalt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Holbrook - son 3148 Park Ave., Apt. 16 Manchester, MD 21102 20b. Place of Disposition (Name of St. John's (Leister's) 20a. Method of Disposition June 2. 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westminster, Maryland 2010 Cometery
22. Name and Address of Facility Fline Funeral Home 21. Signature of Funeral Service License M01072 934 South Main Street Hampstead, Maryland 21074 curry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) diseas Monishell Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year □Yes 2□No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Examiner P.O. Box 68760 attending physician certificate be as. nse õ the detached þ signed by be deta Division of Vital Records, page 2 should has certificate this certific al director,

Physician/Medical Completed After

Physician

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f s Examiner must be notified

Pages 1 and 2 should be filed within 72 hours after death withen of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examinationals.

permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

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Hospital or Attending Physician: The law after death Director: And in by the f

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Medical Certification: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) nin 24 hours af t**he Funeral Di** ppletely filled ir 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number answelling 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. ANSURWA, 2111 Havorez

29d. Date signed (*Month*, *Day*, *Year*)
05-28-20(0

Hampstead MD 21074.

Registrar

31. Date filed (Month, Day, Year)

3 Suicide

4 Homicide

JUN 0 1

6 Could not be determined

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7,8,12 per fd AACO Health Dept 6-1-10 KAH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:19P M May 22 2010 Charles Haste /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner South River Health & Rehab Anne Arundel Edgewater 8. Date of Birth Sept 4 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1**∑**M 2□ F 220-22-6350 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2√2 No r 28a-f sh notified Maryland Anne Arundel Annapolis Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "name" any injury or other traumating. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 130 Hearne Rd. #208 21401 USA Funeral 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced 1947-54 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Economy College (1-4or 5+) Elementary/Secondary (0-12) 8th Supply Store Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Brown Charles Haste Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Md. 21403 Leola Brown(Friend) 910 Windsor Ave 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 6-1-10 Crownsville, Md. 4 Donation 5 Other (Specify) Winniame Reverse of Secilisions Mortuary, P.A. 21. Signature of Funeral Service Licensee Lany S. Bress Moo 483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Vascular direxe Physician Atheroscienotic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Tyes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ivision or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Quadrinegio been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Relention s certificate has b lirector, page 2 s autopsy performed' Bladdes Neurobenic-2 No To the Hose at or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. 50653 7 machice DUB GYAN - C. SUIZANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIVA Deale Rd Churchton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ 9:51 P M William David Hunter, Jr. 2 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗷 M 2 🗆 F Months March 26 1921 Minnesota 214-03-9740 89 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Silver Spring 1 Yes 2 XNo Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 12505 Summerwood Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. White 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steamfitter Fuel Oil Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida May Day ပ William David Hunter, Sr. 19a. Informant's Name/Relationship (Type, Print) Roberta L. Hunter/Wife 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 12505 Summerwood Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State June 8 2010 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death

VIEAR Immediate Cause (Final Physician/ CARDIOVASCULAR THEROSCLEROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Die to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by YPERTENSION 2 No 3 Probably 4 Onknown 1 Tes ALZHEIMER'S DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed 1 Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? Hospital: Other: 2 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar Nam

31. Date filed (Month, Day, Year)

04

2010

8101

PRINCE PHILIP DR

20832

and address of person who completed cause of death (Item 23a) (Type, Print)

MD

.32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02,2000 Holcombe 1844 Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehabilitation and Derina Montgomery Cente 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday **Funeral** June 6, 1915 1 🗌 M 2 🔀 F Months Days Min. 577-07-5918 94 Director N.C. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Montgomery 1 🗌 Yes 2 🏝 No Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3701 International Drive, #719 20906 USA items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married ō ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White "natural", Completed 3 Widawed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Washington, DC Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file h and Mental F 7 is marked of 2 William Lee Holcombe Beulah Elizabeth Mitchell traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Julia Kniskern/Niece 14443 Pebblestone Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State June 04 Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 erence 23a. Part 1. Enter the disease, or complications that caus. Life death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascu disease or condition adays Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by brillaction 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available bleedin 24a, Was an autopsy performe Yes 2 prior to completion of cause of death? After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? upleted filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Other: ည 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending | within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar 30. Name

MD

Trace Brooke HAFman

JUN 0 4 2010

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

18100 Slade School Road, Sand

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilton Hignutt, Sr. Lawrence JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline 16530 Steele Road Henderson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 22 1925 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 A M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Maryland 217-36-0559 85 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Caroline Maryland Henderson 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5 items 23a 21640 II.S.A. 16530 Steele Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 "natural", or 1 ∐Yes 2 X No Specify Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. grain 11 farmer 2 should be filed w and Mental Hygier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Zula F. Madrix James W. Hignutt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16530 Steele Road; Henderson, Maryland 21640 Hazel E. Hignutt/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery June 5 2010 Greensboro, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral PO Box 160 Greensboro, MD 2163 o Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one stude on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TO CARDIOVASCULAR DINISAT Physician TYCUTE /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No N 24a. Was an has page 2 autopsy performe The certificate 2 4 No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 🗆 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar

JUN U3

31. Date filed (Month, Day,

29b. Signatu



and manner stated.

dress of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	, ,	Z U 1 U	18850
			Registrar  1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia		Doris Alvira Howard			Day 2010	3:50 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	l riay 2	4c. County of Death	J.JU I
	LAAIIIII	CI	Caroline Nursing Home	Denton		Caroline	
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		216-12-1859 1 □ M 2 🔼 F 95 Yrs.	Months Days Hours Min.	reb 4ay,19	15 Mary	
7	, ow		Usual Residence of Decedent				
vlanc	-fsh eda	cto	10a. State 10b. County 10c. City, Town or Li			1	0d. Inside City Limits
Z Z	28a notifi	Ë		nton			1 X Yes 2 □ No
ŧ	3a o	Funeral Director	10e. Street and Number	10f. Zip Code 21629		. Citizen of What Cour USA	ntry?
w th	mus mus	ng l	520 Kerr Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe			
C de	or ite	by Fi	1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
036	ral", Exan	b b	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
5-0	natu	Completed		dent's Usual Occupation	168	o. Kind of Business Inc	dustry
27	han a Me	E		kind of work done during most of work OO NOT use retired)	ng		
2	ygien her t it, the	ادها		stress		manufactu	ıring
and	It of Health and Mential Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	<i>'</i>	
<b>1</b>	nark natic		Maurice Dragoo		lay Bartle		
Ma	th an			ng Address (Street and Number or Rura			
<b>6</b>	Heal tem t		20a. Method of Disposition 20b. Place of Disp	8 Kensington Drive		. Location - City or To	
noi age 1	ant of		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		Ridgely, M	
Baltimore, Maryland 21215-0036	Department of H Important: If ite any injury or of						
<b>m</b>	Depar Impor any in		Flye F	2. Name and Address of Facility Leegle and Helfenb O Box 160; Greensb	ein Funer	al Home, I	PA
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en			1039	Approximate
Pi	ysician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ie heart f	0).00		Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or \$3 consequence of):	C MEENU	alloic	3	
E	xaminer	L	Sequentially list conditions, b.				
70	±,	dical Examiner	If any, leading to immediate Due to (or as a consequence by cause. Enter Underlying				
ecute	and -trans	xar	Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):				
oe ex	ohysician and the burial-transit	la E	resulting in death, East				
760 cate b	phys the l	edic	d	·			
687 Sertifica	nding ISe ag	<u> </u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	207/
Box e death o	atter I for u	icia	in the past 12 months? 1 Live Birth 2 Li Fetal death 3	Ctopic pregnancy Other (specify)		Month	Day Year
. B	y the	Physician/Me	9 Unknown				
P.O.	been signed by the attending p should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
ds,	en sig uld b	ed	SEMENTIA		1 🗆 Yes	2 No 3 Prol	oably 4 Unknown
N rec	2 sho	plet	Atrial Fibrillatio	N	24a. Was an autopsy		osy findings available mpletion of cause of
Register In the little	ate has page 2 :	Completed by			performed	? death?	
Za ië	certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Death (Check			
- A	this ce ral dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 🗆 Residence	6 Other (Specify	)
for a giring P	ornera	ate:	27. Mann Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	work?	28d. Describe how in	njury occurred	
Sior	death tor: / the f	E E	Accident Investigation  3 Suicide 6 Could not be	M 1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requires	after death. <b>Director:</b> After I in by the funer	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f, Location (Street City or Town, St	and Number or Rural ate)	Route Number,
Spital D	neral filled	ical	29a. Certifler 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the cause(s	) and manner as state	d.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investionly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the car	use(s) and manner stated.
70 #	To tl		29b. Signature and title of certifier	29c. License number		Date signed (Month, I	
			pures sales To	103/37	6 6	770	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	O. A		110
	- Ct		31. Date filed (Month, Day, Year) 32 Registrar's Signature	20 Manet	STL	9400	48
	Stat Registra		JUN U 2 2010	arka			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Sylvia Mae Hostetler Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Tune 26 1 □ M 2 🗓 F Months Days Hours Min. Day, Ye **Director** Yrs 213-22-5602 85 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a of the Medical Examiner must be Funeral 7726 Scotland Road 21863 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: Completed 3 Widowed 4 Divorced white 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Home of Hand 2 should be filed wit of Health and Mental Hygie of item 27 is marked other in other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester Eugene Miller Alice Claire Yoder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maynard Hostetler 6820 McCabe's Corner Rd. Snow Hill, MD 21863 (Son) timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of cometers crematory or other place)
Snow Hill Mennonite
Church Cemetery Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 1, 2010 Snow Hill, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intestinal Physician/ obstruction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner repsis Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -ibrillation the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension the Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Anatural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 28 May 2010 30. Name and add 9733 Healthway Drive Berlin, MD 21811 Gregory

Registrar

18818

1.00/20/1924

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32. R gistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31, Date filed (Month, Day, Year)

JUN 0 2 2010

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 29 Physician/ Joyce Ann Hart **2**010  $p^{M}$ 8:19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) 1 □ M 2 🙀 F 220-62-5022 Director Washington D.C Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director Maryland 1 Yes 2 X No Charles Nanjemoy 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1755 Port Tobacco Road 20662 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc XX Never Married 2 Married þ Yes 2 No Yes, Give X 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assisstant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Travers Mary Virginia Hart permit. Page 1 and 2 should I Department of Health and Me Important; If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nate' Hart Daughter 1755 Port Tobacco Rd., Nanjemoy, Md. 20662 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placeJune ັ2ິ່0ັ10 injury or 1 X Burial 2 Cremation 3 Removal from State Oak Grove Baptist Church 4 Donation 5 Other (Specify) Nanjemoy, Maryland williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, 21. Signature of Funeral Servi ₩00668 20640 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a. Part 1. Enter the o Approximate Interval Between Immediate Cause Final Onset and Death Com Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pal men Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death 9 D Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital ector, 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) iniun Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D25640

Registrar

DHMH 17 Rev 7/2009

State

7503 Surratts Rd., Clinton, Md. 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Davachi,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norma Karen Hendrickson 8:35р м Mau 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 9106 Kingsbury Drive Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 💆 F Months Days Hours Min 472-44-9250 **Director** Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 9106 Kingsbury Drive 20910 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: Completed White Hygiene. other than "natur rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Librarian Library of Congress 1 and 2 should be filed with of Health and Mental Hygier item 27 is marked other t other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest Adolph Reitan Caren Helene Jensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to David Hendrickson - Son 10116 Lakeside Court, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Buriał 2 🗓 Cremation 3 🗆 Removal from State Baltimore Chemotory at Loudon Park 06/02/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, /232|1800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition months Medical resulting in death) Examiner Biliary Obstruction 3 months Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events l or Attending Physician: The law requires that the death certificate be executed after death. as been signed by the attending physician and 2 should be detached for use as the burial-transit Liver Metastasis 6 months Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital of 24 hours a To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certif Signati 29d. Date signed (Month. Day, Year) 20 June 1, 2010 D18813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Iaucc.,
31. Date filed (Month, Day, Year)
III 0 2 2010 Ira Tauber, 10301 Georgia Avenue, Suite 304, Silver Spring, Maryland 20902

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician . 23 PM GERTRUDE HARRIS 30 it 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S Laurel Paliexent River Health & Rehab If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F 04-16-1919 North Carolina 91 131-38-8402 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Beltsville Maryland Prince George's 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20705 10620 Hockberry Way Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 
Yes 2 
No Pages 1 and 2 should be filed within 72 hours atter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Specify: Specify Completed by Black 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service Food Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Mental Item 27 Is marked o Charlie James Annie Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10620 Hockberry Way, Beltsville, Maryland 20705 James Harris - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o jo 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/11/2010 Hartsdale, New York Ferncliff Cemetery 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Euperal Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Alzheimers Dementia Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unierlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) Pregnant at time of death P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mellitus certificate has been s rector, page 2 should Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation †**⊘**Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Shesadai 29c. License number 29b. Signature and title of certifier Cooler 5 3 411 May 312 2010 Shesadai 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallant Fox Lm F 210 Bowie 20715

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JUN 02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Mildred 29 Harper 7:20 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🏝 F Days Months Hours June 20, Year 1515 577-10-2063 Director 94 D.C. Usual Residence of Decedent show 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified Maryland Montgomery 1 Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2318 Arthur Avenue 20902 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 ☐ No Specify: "natural", 3 ₩Idowed 4 ☐ Divorced White Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home of Health and Mental Hygie If item 27 is marked other ir other traumatic event, th Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If item 27 is marked any injury or -----18. Mother's Name (First, Middle, Maiden Surname) Thomas Edgar Loveless Mildred Teresa Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Harper/Son 2318 Arthur Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State st. John's Cemetery 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home Inc 500 University Blvd. W., Silver Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year the 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an this certificate has ral director, page 2 autopsy performed 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🕇 No Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred X Natural 5 Pending injury work? nours after death neral Director: A I filled in by the fu Accident
Suicide
Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Medical 29a. Certifie Example 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certi 29c. License number 29d, Date signed (Month, Dav. Year) D39793

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signature

18111 Prince Philip Drive, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Christopher J. Mays, MD

June 1, 2010

1 - For State Registrar 1. Decedent's

29a. Certifier

(Check only one)

ven 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

**Physician** /Medical

Examiner

Director

Funeral

Completed by

Be

မ

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

**Funeral** Director

For State Registrar			(	Cert	ificate of l	Death	Reg	. No.	0 1 0	18857
	e (First, Middle, Last) Mary Grad	e Hawkins					2. Date of Death Month	Day	Year	3. Time of Death 10:35 P M
Facility Name (	f not institution, give s				4b. City. Town or	Location of Death	June 1, 20		ounty of Deat	
	shington Hosp				Fort Wash				ince Ge	
Social Security N	umber 6. Sex	7. Age	(In yrs. last birth	day)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y			hplace (State or Foreign
220 12 20 ual Residence of	))))	M 2₹F	92 Y	rs.	Month Days	TIOUTS WITH	March 11,	1918		hington DC
a. State	10b. County	•	10c. City, Town							10d. Inside City Limits
Maryland	Prince Geor	rge's		C	linton					
. Street and Nu 952	nber D Badger Ave				10f. Zip Code 2073	5	10g		n of What Co rited St	•
Marital Status		12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	
1 □ Never Mari	ied 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes XX N If Yes, Give Year or Dates:	lo		□Yes 2M∏ No	Specify:		s	pecify: B1	
(Spe	15. Decedent's Educity only highest grade		16a. E	ecede Give ki	nt's Usual Occup	ation during most of worki	ing 16	b. Kind	of Business/	/Industry
Elementary/Seco	ondary (0-12)	College (1-4or 5	+)		o NOT use retired <b>ekeeper</b>	2)		Dome	estic	
	(First, Middle, Last)					18. Mother's Name	(First, Middle, Ma	iden S	urname)	
	iam D. Waters	S				Ella F	. Newman			
a. Informant's N	ame/Relationship (Ty)	pe. Print)				and Number or Rura				
Leon W	aters (SON)		33	48 H	lunt1ey Squ	are Drive A				
a. Method of Dis	position □Cremation 3 □R	emoval from State	1	, crema	atory or other plac	ce)			ation - City or	
4 □ Donation	5 ☐ Other (Specify)					etery June 7	,		on, Mar	•
. Signature of Fi	uneral Service License	$\hat{n}$ . $0m$	52210			ss of Facility Lee Clinton, M		ne, li	IC 0033	Old Alexandria
Ba. Part. Enter shock, or hea	the disease, or compli art failure. List only or	cations that caused ne cause on each lir	the death. Do no	ot ente	r the mode of dyir	ng, such as cardiac	or respiratory arres	it,		Approximate Interval Between Onset and Death
mediate Cause sease or condition		cardi	online	40	vy a	rest				Onset and Death
sulting in death)		Due to (or as	a consequence of	f):	0	6.1				
equentially list co	onditions,	Due to for as	a Sonsequence of	و D:	wear!	- fail	WC			
any, leading to in use. Enter Undo ause (Disease or	injury	La lo (or as	10/ 60-	, a		(				
at initiated event sulting in death)	S C	Due to (or )	a consequence o	): ():	~					
		J								
=======================================										
FEMALE:  3b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnanc Other <i>(specify)</i> _	у		23	d. Date of de Month	elivery Day Year
	ficant conditions cor	ntributing to death b	ut not resulting in	the une	derlying cause giv	en in Part I.	23e. Did toba	cco us	e contribute t	to the cause of death?
3		_					1 ☐ Yes	2 🗷	No 3□P	robably 4 □Unknowr
							24a. Was an autopsy		24b. Were a	utopsy findings available completion of cause of
							perform	ed? No	death?	s 2□No
. Was case refe examiner?	_	1			Te		h (Check only one	)		
1 ☐ Yes 2 Z	140	Hospital: 1 Inpatie				4 LI Nursing Ho	ome 5 Resider			ecify)
. Manner of Dea	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Ti y Yea <i>r</i> ) In	ime of jury	28c. Inju Wo	ry at rk?	28d. Describe hov	v injury	occurred	
1  Natural 2  Accident 3  Suicide	investigation 6 Could not be		ury - At home, fan c. (Specify)		M 1	Yes 2□No				

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has

Physician

/Medical Examiner

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11711 Livinston Road, Fort Washington, MD

32. Registrar's Signature

parket

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

10

20744-5164

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland /	Department of H Certificate of D		lental Hygier Reg. I	2010	8858
Physicia		1. Decedent's Name (First, Middle, Las	,			2. Date of Death Month	Day Year	3. Time of Death
Medio Examir		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or	Location of Death	<u> </u>	1 2010 c. County of Dear	<del>- J</del>
Funeral		Social Security Number     6. Security Number		thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince g. Bir	thplace (State or Foreign
Director		056 366531 1 Usual Residence of Decedent	□M2▼F 63	Yrs. Months Days	Hours Min.	8. Date of Birth Month, Day, Year	46 NE	W York
ryland I-f shov ied at	ctor	10a. State 10b. County	10c. City, Tow					10d. Inside City Limits 1
the Ma a or 28g	I Dire	10e. Street and Number		10f. Zip Code			Citizen of What Co	/-
ath with ems 23s	unera	6706 West For	rest Road  12. Was Decedent Ever in U.S.	20785			14. Race - Ame	rican Indian
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 KD Divorced	Armed Forces?. 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates.	If Yes, specify Cubar 1 ☐ Yes 2 🕱 No	n, Mexican, Puerto F	Rican, etc.)	Black, Whit	e, etc.
Maryland 21215-0036 I should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam		15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)		a. Decedent's Usual Occupa (Give kind of work done du life, DO NOT use retired)	uring most of workir	ng N	Kind of Business Ew York Lice De	City
Maryland Se should be filed vental Hyg is marked other traumatic event,	To Be	17. Father's Name (First, Middle, Last)	ole		18. Mother's Name	(First, Middle, Maide Ruff	n Surname)	
Mary 12 should 14th and Mary 27 is me		19a. Informant's Name/Relationship (7)		b. Mailing Address (Street a				Code)
Baltimore, I permit. Page 1 and Department of Heal Important: If item 2 any injury or other one.		20a. Method of Disposition 1 ☐ Burial 2 🛪 Cremation 3 ☐	20b. Place of	157 Hunter of Disposition (Name of erry, crematory or other place	e) D	ate 20c.	Location - City or	
Baltimore, permit. Page 1 and Department of Hes Important: If item any injury or othe once.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Services Licens	) Metro	Politan Crena 22. Name and Address	s of F cility	4/10 Al	exandrice rai Hom	a, VA
Baj permi Depar Impo any ir			renel	1814 Frank	lin StJ	Hexandri	a, VA 2	2314
Physician/	67. 6	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	not enter the mode of dying	i, such as cardiac oi	r respiratory arrest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequence					
7 =	niner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):				
executer an and ial-trans	l Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence	of):				
760 cate be physicia the bur	edical		d					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3  Ectopic pregnancy 5  Other (specify)	/		23d. Date of de Month	livery Day Year
ords, P.O. B.	b	Part II. Other significant conditions or	ntributing to death but not resulting	in the underlying cause give	en in Part I.			the cause of death?
<b>Division of Vital Records,</b> tal or Attending Physician: The law requires rs after death.  I Director: After this certificate has been siged in by the funeral director, page 2 should be	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
of Vital B Physician: 1 Physician: 7 Physician: 7 Physician: 7 Physician: 7	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Other	r:	only one) me 5 🗹 Residence	6 C Other (See	(6.1)
on of \nding Phy ath. : After this e funeral o	cate: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury 28b.	Time of 28c. Injury injury work?	at 2	28d. Describe how inj		ny)
Division of tall or Attending P rs after death. al Director: After ted in by the funera	d Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	28f. Location (Street a City or Town, Sta		ral Route Number,
Div To the Hospital or within 24 hours aft To the Funeral Dir completed filled in	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ician: To the best of my knowledge, her: On the basis of examination and/o e Practioner: To the best of my know	or investigation, in my opinion rledge, death occurred at the	n, death occurred at time, date and place	the time, date and pla e, and due to the caus	ce, and due to the e(s) and manner as	cause(s) and manner stated. stated.
To with		29b. Signature and title of certifier  A Stayagachel M 1 1	> .	29c. License	7 4 6 5		Date signed (Mont)	h, Day, Year)
R3		30. Name and address of person who con the control of the control	2835 SmiTh Av.	5-235,	Baltimor	P,MD.	21209	
Stat Registra		31. Date filed (Month, Day, Year)  JUN 0 3 2010	32. Registrar's Signature	ad				
DHMH 17 Rev 7/20	na		7					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** PRISCILLA Ε. HOLLAND May 28, 2010 7:40 А /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edward W. McCready Memorial Hospital Crisfield Somerset Age (In yrs. last birthday, 91 Yrs. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 TF Jan. 31, 1919 Director 220-05-5434 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>28 Hall Highway</u> 21817 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No ş Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otis P. Evans Lydia Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Bryan Holland (Son) 2044 Bypass Road - Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) Sunnyridge Memorial Park June 2, 2010 Crisfield, Maryland Juneral Service Loghs 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Mary Bern Bradshaw 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** DIVERTICULITIS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş SCV 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D 48098 281 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pr. Vyay Kaumbernatian 201 Hall Highway, Cristield

Registrar DHMH 17 Rev 1/2001

State

Dr. Vyay 31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Of Maryl Registrar		rtificate of L			Reg. No.	10	18860
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		ROSE ANNA HALL				May		2010	4:30 A M
1	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		1	4c. County	of Death	
			Alice Byrd Tawes Nursing Home  5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	isfield If Under 24 Hrs.	8. Date of Birt	h	Somer	
b	Funeral Director		216-14-2214 1□M 2只F 8	- Vre	Months Days	Hours Min.	Nov. 22	v. Year)	Maryl	ace (State or Foreign ry) .and
	yland low at		Usual Residence of Decedent           10a. State         10b. County         10c.	. City, Town or Lo	ocation				10	d. Inside City Limits
	Mar B-f st	jo	Maryland Somerset		Cri	sfield				1 Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Count	ry?
	th will		300 Somers Cove Apts.			2181	7		US	A
	ems ems	Funeral	11. Maritai Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	- 14. Rac	ce - America	
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2¶ No	Specify:	o 1 nouti, otc.)	Specif	T 71 .	
215-0036	72 hor	sted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation	kina	16b. Kind of B	usiness/Indu	ustry
121	e filed within 72 h al Hygiene. I other than "natu vent, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired	)	9	Marand		
N	Hygie Hygie ther i	ပ္	11. Father's Name (First, Middle, Last)		Nurse	18. Mother's Nan	ne (First, Middle,	Nursi		
yland	d be sental	To Be	John Cole DeHaven				aroline		,	
<u></u>	shoul nd M marl	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a					Code)
Mar	nd 2 alth a 27 is		Peggy Zennora Hall Hess (Daug							
ē,	item othe		20a. Method of Disposition 20	b. Place of Dispo		i	Date	20c. Location		
Ē	permit. Pages 1 Department of F Important: If ite any Injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ptist_Cemet		22.2010	Rehobet	h. Mai	ryland
baitimore,	mit. porta y Inju		21. Signatury of Funer prervice Licensee		2. Name and Addres		RADSHAW			-79
מ	B a m c		Mary Hoth Branch by Britt	) 30	06 W. Mai					
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	leath. Do not ent	ter the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate interval Between
	Physician		Immediate Cause (Final disease or condition	45 C	v.D					Onset and Death
,	/Medical Examiner		resulting in death)  Due to (or as a con	sequence of):						
	· 李二·	er	Sequentially list conditions, if any, leading to immediate course. Enter Uniter Sequence (Disease or injury)	sequence of):						
	cuted	Examiner	that initiated events						-	
Ď,	tificate be executed g physician and as the burial-transit	EX	resulting in death) Last Due to (or as a con	sequence of):						
00/00	cate b	edical	d				<del></del>			
	certific		IF FEMALE: 23c. If yes, outcome pf pre	egnancy				004 D		
Š O D	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other <i>(specify)</i>			I .	ite of deliver onth [	y Day Year
Ċ.	requires that the death een signed by the atter nould be detached for L	Physician/M	9 □ Unknown 9 □ Unknown							
ν̈́ L	es tha gned se det	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	,	tribute to the	e cause of death?
ecords	equin		TYPE IT DM				1 🗆 '	res 21 No	3 ☐ Proba	ıbly 4 □Unknown
	The law rate has be bage 2 sh	Completed					24a. Was autor		Were autop	sy findings available pletion of cause of
	The zate h	5					perfo 1 Yes	rmed?	death?	2□ No
	clan; entific ector,	Be (	25. Was case referred to medical examiner?		T	26. Place of Dea	th Check only o	ne		
	shysl this c	ို		2 ☐ ER/Outpatier		4 PS Nursing H	lome 5 ☐ Resid			)
5	nding F tth. r: After e funer	ation:	27. Manner of Death  1, 1 Natural 5 □ Pending (Month, Day Yea.  2 □ Accident investigation	r) 28b. Time o	Work	/ at ⟨? Yes 2 □ No	28d. Describe I	now injury occur	red	
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp	at home, farm, str ecify)	reet, factory, office		28f. Location (S City or Tov	Street and Numl vn, State)	ber or Rural	Route Number,
	e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	To th To th	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signe	ed (Month, D	Pay, Year)
	XHI		V W +9		D	93098		5/18	2010	)
	le		30. Name and address of person who completed cause of death (  Dr. Vijay Kaumbunatt		Print) Hecll	Highu	cay (	isteld	mp	21817
(P)	Stat	e	31. Date filed (Month Pay 727) 2010 32. Figistrar's Si		he vil		J-/-/	V.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month MAY Physician/ Day Year 2010 ETHELENE EDITH JACKSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 TXF 213-18-8382 100 Yrs <u>1</u>919 Director Usual Residence of Decedent J Hygiene. Jother than "natural", or items 23a or 28a-f show vent, the Me Ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Directo 1 X Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 323 Madison Street 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ☐ Yes 2 🗓 No 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give 3 Widowed 4 Divorced **Black** Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be flik Department of Health and Mental I Important: If item 27 is marked o Louis Morrison Ada Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madison Street, Frederick, MD 21701 Jonnieta Hall /\_Granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State injury or 5/28/2010 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mude and Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 d guipt se as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 2 🗌 No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: 2 No ဂ္ 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) MD 0056890 3010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (sect SWD snika 610 21 rea 31. Date filed (Month, Day, Year 32. Registrar's Signature State JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#23a, pt I, 25, 27, 28a-f, perME, G905, 7, 26, 2010, WS State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 M F 571-13-0173 38 CA Yrs 1-13-1972 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DE Kent Dover 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 814 19901 Maple Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the compared to the 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Itome Itome maker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ည Jones dorma June 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Maple Parkway. Dover. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 2810 Dover, De 21. Signature of Funeral Service Licensee 615 Bradford Willen 101 52 Chapel- Dover. De 19904 Funeral Turbert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatic Failure Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition /Medical resulting in death) **Examiner** Acetaminophin ToxicIty Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Or do a consequence of: Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? 2 No Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 X Yes - 2 1 2 ER/Outpatient 3 DOA မ 28a. Date of Injury
(Month, Day Year) funeral 27. Mayer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury After T Natural 5 Pending investigation May 25 2010 | Tinknown | 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) death. 2 Accident 1 🗌 Yes the 1 Unknown Director: 3 Suicide 6 X Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State**Ind: 814 Maple Parkway** filled in by determined 4 - Homicide Vnd: At home Dover, DE 19901 within 24 hours a 29a. Certifier 1 F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Robert William Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Talbot -aston If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗓 M 2 🗆 F Months Days Hours Min November 2, <sup>ear)</sup>1931 Mary Land **Director** 217-28-4497 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Tes 2 X No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? Examiner must be Funeral or items 23a United States of America 21629 26668 Burrsville Road 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married ò 2 □ No 1951 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Caucasian 3 Divorced 4 Divorced 1954 Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Employee Nylon Production 11 HS grad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lola Sipple Malone Jones Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26668 Burrsville Road, Denton, Maryland 21629 Anna D. Jones 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/27/2010 Denton, Maryland Denton Cemetery 4 Donation 5 Other (Specify) Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South Second Street, Denton, Maryland 21629 23a. Vart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or se a consequence of) cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No or Year 5 Other (specify) Month Dav Pregnant at time of death signed by the ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 performed? Yes 2 N this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) B B examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗌 Yes 2 > 10 မြ 1 Anpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No.

State Registrar

Accident

Suicide

3

Dennis DeShields,

4 Homicide

only one) 29b. Signature and title of certifie

31. Date filed (Mon

29a, Certifier

Investigation

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

M.D.

DHMH 17 Rev 7/2009

24 hours after deat Funeral Director:

within 2 To the F

filled in by

completed

Medical

🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

219 South Washington Avenue, Easton, Maryland

29c. License number

1)005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

gistrar's Signatur

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month. Dav. Year)

2010

21601

			Pleas nended Item 8 per	se Type or Pr F.D. 05/2 State of M	i <b>nt in Blac</b> 7/2010 C laryland					Copies ental Hy	Are L	Legible	e.
			1 - For State Registrar			Certific	ate of	Death	7		Reg. No.	UIU	0004
н	Physici	an	Decedent's Name (First, Middle,		_					Date of De		Ye	3. Time of Death
7	/Medi		Brian	Scott		eznacl				ay 22		)10	1/:30 рм
	Examir	ner	4a. Facility Name (If not institution, Univ. of Mary	land Medi	cal Cti	c. B	alti	more				County of D	
	Funeral Director		5. Social Security Number 215–80–5031  Usual Residence of Decedent	5. Sex 7. A 1 □ M 2 □ F	ige (In yrs. last bi	Yrs. If Ur Mont	hs Days	If Under Hours	Min.	Anne of M (Month, D	196 7 196	-Δ	Birthplace (State or Foreign Country) Maryland
	fand ow		10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
	Mary I-f sh	to	Maryland C	arroll		West	ninste	er					1 Mary Yes 2 □ No
	h the	irec	10e. Street and Number			10f.	Zip Code	-			10g. Citiz	zen of What	t Country?
	th with 23a (23a)	ral	450 E. Green S	st.			21	157				Ţ	JSA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Madicol Evergine must be notified at once.	y Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Marrie  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 TYes 2 If Yes, Give Year or Dates	? 1978		ecedent of I specify Cub s 2 🗽No		rigin? (Speci an, Puerto Ri /:	fy Yes or No can, etc.)			American Indian, Vhite, etc. White
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pu	e file al Hy I othe vent,	Be (	17. Father's Name (First, Middle, L.	ast)				18. Moth	ner's Name (i	First, Middle	, Maiden S	Surname)	
Maryland	ould by Ment arkec	၉	Stephen Jeznach					Maı	rgaret	Ann '	Wilsc	n	
Nar	2 sho		19a. Informant's Name/Relationshi			b. Mailing Add							
	1 and Health Sm 27 ther t		Josephine Jezna 20a. Method of Disposition	Cn/wire		50 E. (		<del></del>	Westm				or Town, State
Baltimore,	nt of nt of reference of or or or or or or or or or or or or or		1 ☐ Burial 2 🔀 Cremation 3		∍	of Disposition ( ery, crematory		· i				·	
Ħ	artme vrtani injury	li	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Carrol				05/25 Home (19				l, Maryland
Ва	Depa Impo any i		21. digitature of runeral dervice El	- Certisee									ID 21157
			23a. Part 1. Enter the disease, or c	omplications that cause	ed the death. Do					100	100	~L, I.	Approximate Interval Between
2	Physician		shock, or heart failure. List o Immediate Cause (Final		<sub>line.</sub> tic Bra	ain Tn	יייוולי			n/			Onset and Death
	/Medical		disease or condition resulting in death)	a	s a consequence		Jury		1 10	1 epo			
	Examiner							1	Mar	N. J. J. J. J. J. J. J. J. J. J. J. J. J.			
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	e executed ian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с				NOY	M By W.				
50,	be ex cian a vurial-	<b>—</b> I	resulting in death) Last	Due to (or a	s a consequence	of):	7/	N REE	ONEO B.				
9289	ficate by physici s the bu	dica	•	d		(	9/ W	CATION F				<del></del>	
9 X	ding se as	Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy		CERT	TICATION RPFE				01 0-1	r de libre m
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 Fetal death	h 3 ☐ Ectop 5 ☐ Other	ic pregnanc	у				3d. Date of: Month	Day Year
σ.	that the ded by detach		Part II. Other significant condition	s contributing to death	but not resulting i	n the underlyin	ng cause giv	en in Part I	I.	23e. Did	tobacco us	se contribut	te to the cause of death?
Records,	ulres n sign ld be	d by								1 🗆	Yes 2	⊒No 3⊑	Probably 4 Unknown
S	w require s been sig should b	Completed								24a. Was	an	24b. Wer	e autopsy findings available
Re	: The law cate has page 2 (	щ								auto	psy ormed?	prior deat	r to completion of cause of th?
Vital	lcian: Th certificate ector, pag	G)	25. Was case referred to medical					26 Place	e of Death (	1 □ Yes		1 🗆	Yes 2□No
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Σ̈́	or Att ter de irect	ij	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of it	njury - At home, fa etc. <i>(Specify)</i>	arm, street, fac	tory, office		140	f. Location ( City or To	Street and wn, State)	Number o	r Rural Route Number, East Green
Ω	ital curs at ral D			Alle									East Green
	To the Hospital or Attendii within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1X Certifying (Check only one) 1 Medical E	Physician: To the bes xaminer: On the basis and manners	of examination a	e, death occur nd/or investiga	red at the ti tion, in my	ime, date a opinion, de	and place, an eath occurred	d due to the	e cause(s) , date and	and manne place, and	er as stated. due to the cause(s)
	Vith Vith Com	Σ	29b. Signature and title of certifier				29c. Licens P189					e signed (M	fonth, Day, Year)
	WILVA		10000	an				J .			1	/	· -
	1511		30. Name and address of person w Dr. Jill B. Ha	ho completed cause of alonen 22			t. B	alto	, Md	2120	1		
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 20 SONYA DENISE JOHNSON JAMIESON 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL LAT HARI CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 231-15-1233 NOVEMBER 13, 1964 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√€ No MARYLAND CHARLES LA PLATA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10630 HORSESHOE PLACE 20646 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILBERT MCKINLEY JOHNSON MATTIE ETHIEL JONES JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY E. JAMIESON, JR./HUSBAND 9115 POOR HOUSE ROAD, PORT TOBACCO, MARYLAND 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ cremation 3 ☐ Removal from State BRINSFIELD-ECHOLS CREMATORY JUNE 5, 2010 | CHARLOTTE HALL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenson THORNION FUNERAL HOME, P.A. MATDIA C. THORNTON JOHNSON MO0583 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcho disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 2 Accident 1 ☐Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed and signed by the attending physician I be detached for use as the burla

After

Division of Vital Records, P.O. Box 68760,

Physician/Medical \$ Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

23a or 28a-f show

Director

Funeral

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Completed

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event, the 'Madeal Examiner must be notified at

"natural", or

is marked other

permit. Pages 1 and 2 and 2 bepartment of Health an Important: If item 27 is any injury or other trauonce.

**Physician** 

/Medical

Examiner

Maryland

Baltimore,

Pages 1 and 2 should I

24 hours a Medical (Check only one) within 2 29b. Signature and title of certifier

29a, Certifier

3 Suicide

4 Homicide

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D57708

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

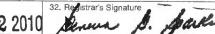
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENNAMED, CTR. 7-CPOSTOFFICERD MD 31. Date filed (Month, Day,

State Registrar

Year) JUND

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elaine Yvonne Johnson  $05 - 2^{1} - 20^{1} = 0$ 12:27p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number)
Shady Grove Adventist Hospital 4b. City, Town, or Location of Death ROCKVILLE Examiner MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 579-80-1965 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 2000 2 ax 1 8 5 6 1 - M 2 - F Months <sup>Country</sup>irginia 53 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD ROCKVILLE MONTGOMERY 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States filed within 72 hours after death with 1238 First St 20850 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc 1 X Never Married 2 Married Completed by 2**X** No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates er than "natur the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Government <u>Food Service</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Leana Jordon ပ Robert Lee Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Johnson ( Brother First St Rockville MD 20850 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremator) (Index market or y Riverdale Park 6-1-2010 Riverdale Maryland 4 Donation 5 Other (Specify) 21. Signature of eral Service Licenses 22. Name and Address of Facility A. Sanders & Sons Mortuary 13329 Woodbridge ST Woodbridge, VA 22191 23a Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Gram Negative Rods Septicemia Medical Due to (or as a consequence of Examiner Acute Pancreatitis Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 2 🗌 No 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed ligirector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ tX☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending XNatural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05-21-2010 WD D0066656 tallege

State Registrar Oluwadelumi

31. Date filed (Month, Day, Year)

arke

Medical Center DR. Rockville, MD 20850

9901

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fakeve

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	e of M	arylan		artment of I		and N		/	010	18867		
			Registrar  1. Decedent's Name (First, Midd.	le, Last)			Cei	Lincate or i	Jeaur		2. Date of De	Reg. No.	3. Time of Death			
	Physicia Medio	al	Arthur	J					Month May	26	2 <b>0</b> 10	3:15 а м				
	Examin	er	4a. Facility Name (if not institutio	, ,			4b. City, Town, c					unty of Deat	eorges			
	Funeral		208 Flaim Lane 5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under 1 Year			8. Date of Bir	th	9. Birt	hplace (State or Foreign		
	Director		224-76-2502	1 🔀 M 2 🗆	F	58	Yrs.	Months Days	Hours	Min.	Mar . 2	9 Year 195	2 Cou	untry) VA		
	nd now	'n	Usual Residence of Decedent  10a, State 10b. County	/		10c City	, Town or Loc	eation						10d. Inside City Limits		
	arylar ta-fsh	Director		e George	es		. Wash							1 ☐ Yes 2¾ No		
	or 28 or 28 e not	Δ	10e. Street and Number	00018		10,	, madi	10f. Zip Code			Т	10g. Citizer	10g, Citizen of What Country?			
	s 23a ust b	Funeral	208 Flaim Lane	2				207	44			US	SA			
	death item ner m							Vas Decedent of H	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White				
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Widowed 4 Divorced Year or Dates.				1	☐ Yes 2 🔀 No	Specify:			Spe		Black		
9-0	hours natura lical E	lete	15. Decede		16a. Deced	ent's Usual Occup	ation			16b. Kind	of Business I					
218	e flied within 72 hours after death with the Maryland tral Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only high Elementary/Seconday (0-12)		eted) je (1-4 or 5	5+)	(Give kind of work done during most of working life. DO NOT use retired)							·		
21	iled within 72 I Hygiene. other than ' rent, the Me	Be C		Commu	nity Supervisory Officer DC Boar  18. Mother's Name (First, Middle, Maiden Surname						f Parole					
Maryland 21215-0036	be filed antal Hy ced oth c event	10 B	17. Father's Name (First, Middle, Arthur James	Last)							e (First, Middle, lount	Maiden Sun	name)			
Z	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relations	ship (Type, Print)			19h Mailin	g Address (Street				r City or Toy	un State Zin	Cada		
	d 2 sh alth a 27 is er trau		Marva James -					Flaim La:			Washing			744		
ore,	of and 2 should be file of Health and Mental Health and Mental Health 27 is marked or other traumatic ever		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	0 D B14		20b. PI	lace of Dispos	sition (Name of natory or other place	re)	[	Date	20c. Locat	ion - City or	Town, State		
ij	Page ment ant: I		4 Donation 5 Other		rom State	1		tan Crem	· '	5-28	8-2010	Alexa	ndria	, VA.		
Baltimore,	permit. Page 1: Department of P Important: If it any injury or of		21. Signature of Euneral Service	Licensee	W	ruds	ノが、	Name and Address arshall 308 Suit	ss of Facilit S Fun Land	ĕral Rd.	Home o Suitla	f Mary	71and 20. 20	746		
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications the	nat caused	d the death					r respiratory an	rest,		Approximate Interval Between		
mara.	Physician/		Immediate Cause (Final disease or condition	Car	ncer	Sma13	l Inte	stines						Onset and Death 4 years		
	Medical Examiner		resulting in death)	Due	to (or as a	a consequ	ence of):									
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	exect an an rial-tra	EX	resulting in death) Last	Due	to (or as a	a conseque	ence of):									
09	cate be executed physician and the burial-transit	edical		d												
687	ertifica ding p se as t		IF FEMALE:	23c. If yes,	outcome	of pregnar	acy.									
Box 687	res that the death certific signed by the attending I I be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 □ L	ive Birth		death 3	Ectopic pregnand Other (specify)	СУ			23d	. Date of deli Month	,		
B.	the de	hysi	9 Unknown		Jnknown											
P.O.	that the		Part II. Other significant conditi	ons contributing	to death b	ut not resu	alting in the u	nderlying cause gi	ven in Part	l.	23e. Did to	bacco use	contribute to	the cause of death?		
ds,	requires been sig should b	ted									1 🗆 '	Yes 2 🛣 N	No 3 🗆 Pr	obably 4 🗆 Unknown		
COL	law re las be	Completed by									24a. Was autop		prior to c	opsy findings available ompletion of cause of		
Re	ician: The law certificate has rector, page 2											rmed? 2 No	death?	2 🗆 No		
ital	sician certifi rector	Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:				Oth	ace of Dea							
of V	Physer this eral di	e: To	27. Manner of Death	28a. D	ate of inju	ry :	ER/Outpatien 28b. Time of	28c, Injur	4		me 5 🔽 Resid			fy)		
on	ath. r: Afte	icat		igation	Aonth, Day	, Year)	injury	M 1 🗆	? Yes 2 □			,,				
Division of Vital Records,	r Atte ter de irecto ir by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Pl	ace of Inju	ry - At hor . (Specify)	ne, farm, stre	et, factory, office	_		28f. Location (S City or Tow	ion (Street and Number or Rural Route Number,				
Ö	pital o															
	Hosp 24 ho Fune eted f	ledical	(Check 2 L Medical	Examiner: On the	basis of ex	xamination	and/or investi	ccured at the time gation, in my opinion	on, death oc	curred at	the time, date a	nd place, and	d due to the c	ause(s) and manner stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Σ	only one) 3 L Certifying 29b. Signature and title of certifie		en. IO INE	pest of MA	Miowieage, a	eath occurred at the 29c. License		and plac			gned (Month			
			· Cynthia	mon	re	can	rs, DC	Э НОО5	8032			May 28	3, 201	0		
۸	10		30. Name and address of person  Cynthia M. Wi	who completed o	cause of de	eath (Item :		rint)	ashin	gton	, DC					
	Stat	-	31. Date filed (Month, Day, Year)			ar's Signatu		DC 1111 W		0-011	,					
	Registra	ir	JUN 0 3 2010	carrie	10.	7					,					

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			State of Maryland / Department of Health and M 2 per dr., g904,06/16/2010dhb Certificate of Death	lental Hygie Reg.	ne . No 0   0	18868	
	Physicia		1. Decedent's Name (First, Middle, Last)  VYON REGINALD KOMPGAY	2. Date of Death 0	5/07/2010 Pay / 2	3. Time of Death 9:974 M	
\ 	Medic Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. Facility Name (if not institution, give street and number)	475	4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth		
		or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1/21/1		10d. Inside City Limits	
	e Maryla r 28a-f s notified	Director	MO P.G CAPITAL HEIGHT'S	140	Citizen of Mines Court	1 Fres 2 No	
	h with th ns 23a o nust be	Funeral	6414 GRA STIEET #202 20743		Citizen of What Cou		
9800	urs after deat ural", or iten il Examiner r	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give Year or Dates.  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Forces)  1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	etc.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	ng 168	b. Kind of Business In	^	
land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  ARR	(First, Middle)Maid	den Surname) // Wi150	J	
Maryland	d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  19c. Vory Kornegay/Neplew  4607657.DE-W		y or Town, State, Zip	Code)	
Baltimore,	Page 1 and neut of He int: If item int or other		Cemetery, crematory or other place)	Y/10 200	C. Location - City or To		
Balti	permit. P Departri Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facily  23. K. HENV LUNGS	1	(120 H.C.	1. 12. C. 20002	
	hysician/	ė v	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)			Approximate Interval Between Onset and Death	
Same.	Medical Examiner		resulting in death)  Due to (or as a consequence of):  ATHER COLED OF COLED	7 01.5	FAST		
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		- / -		
	ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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ls, P.0	uires that t n signed b ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to t	he cause of death? bably 4  Unknown	
Division of Vital Records,	The law req ate has bee page 2 shot	Completed	Dédectes Melliting	24a. Was an autopsy performed 1 Yes 2	prior to completion of cause of death?		
/ital	s certific director,	To Be	25. Was case referred to medical examiner?  1		e 6 Other (Specifi	<i>A</i>	
on of \	nding Phy ath. : After this e funeral c		07 U (D II	28d. Describe how in			
ivisio	I or Atte after des Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and so fexamination and/or investigation, in my opinion, death occurred at the time, date and place only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and p	lace, and due to the ca	use(s) and manner stated.	
	To the within comp	_	29b. Signature and title of certifier  29c. License number		Date Agned (Month,		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  YUDH GOPTA 106 Trving Street N.W.#20	Mash	.D.C., Z	0010	
	Stat Registra		31. Date filed (Month, Day, Year)  JUN 1 6 2010  22. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH G904 6/25/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Month Mary Ella Kirkland 30 2:: 55 P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Upper Marlboro 14711 Dunbarton Drive 1920 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 28 (Month, Day, Year) **Funeral** 1 □ M 2 🕇 F Months Days Hours Min. <del>20</del>Alabama 90 Director 379-22-7377 March Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 □ No MarylandPrince Georges |Upper Marlboro 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral death with 20772 USA 14711 Dunbarton Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc ğ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry المالية المال (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife none ould be filed with nd Mental Hygien marked other ti 12th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Laura Ward Herbert Childs and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 8012 Tiffany Lane Lanham, MD 20706 Zeigler/Daughter <u>Retta K.</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) incoln Memorial ark permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State June 7,2010Clinton Township,MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home 20011 Signature of Funeral Service Licensee W. Washington DC 3831 Georgia Avenue, N. cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Mailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Aortic Stenosis Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a Id be detached 1 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ <u>Cerebrovascular Disease</u> 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? has certificate 1 Yes 2 No Hospital or Attending Physician: The 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 🖳 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Acciden 3 Suicide 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after hours Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) è mo 0 June 6, 2010 D25079 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20706 #300 Lanham, MD 8116 Good Luck Rd. Yablonwitz, MD Don H. 31. Date filed (Month, Day, Year) State **JUN 03** 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Diane Brenda KAMMERMAN Physician/ Jumen 1, 2010 1:16 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 і і F Months Hours Jan. 14, Year 1939 New York Director 117-30-3677 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Rockland Clarkstown New York 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10989 United States 958 Tilton Road (Valley Cottage 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🕅 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates ge 1 and 2 should be filed within 72 hours nt of Health and Mental Hygiene. t: If item 27 is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Children's Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Birnbaum Edna Marenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11020 Earls Gate Lane, Rockville, MD 20852 Joyce Kammerman, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Important: If any injury or Mt. Lebanon Cemetery | 06/04/10 Glendale, NY Signatu Torchinsky Hebrew Funeral Home 20012 254 Carroll St. NW. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Enysician Pulmonary Edema disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infarction Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 💢 No 9 ☐ Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 XNatural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death declared at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Ewithin 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) ane 068178 June, 01,2010

DHMH 17 Rev 7/2009

Registrar

Santosh Rane, M.D.,

JUN 03

31. Date filed (Month, Day, Year)

20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Santosh Rane, M.D., 9901 Medical Center Drive, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27 ay May 2ੴ10 11:00 A M Evelyn I Kelly Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 01ney Montgomery General Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Jan 24, 1 □ M 2 🔀 F Hours Min Washington, DC Director 91 Yrs 1919 578-01-7618 Usual Residence of Decedent and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 200 construction or other transmation. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 R No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 15115 Interlachen Dr. #715 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Caucasian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George B. Ingels Grace Van Fossen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 14500 Gallant Fox Lane, Gaithersburg, MD 20878 Dennis P Kelly, Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1  $\square$  Burial 2  $\searrow$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Ft. Lincoln Crematory 6/4/2010 Brentwood, Maryland Signature of 22. Name and Address of Facility Simple Tribute Service Licenses 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of Examiner neuwonice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine failuil Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has ral director, page 2 s autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Certificate: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 withIn 24 hours after deat To the Funeral Director: pleted filled in by

> State Registrar

only one)

30. Name and addre

3

29b. Signature and title of pertifier

ss of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

18101 Prince Phillip Dr. Olney, MD 20832

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Russell D. Kirk 4:02 AM May 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince Hospital Laurel -aure George s If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct 1.20,1918 9. Birthplace (State or Foreign OHIO) Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 285-07-0601 1 X M 2 □ F 91 Months Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exymetriust be notified at once. 10c. City, Town or Location Silver Spring 10a. State 10b. County 10d. Inside City Limits Maryland Montgomery 1 □Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3126 Gracefield Road, #113 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give 1942-1946 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Naval College (1-4or 5+) Elementary/Secondary (0-12) Research Lab Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard D. Kirk Clara O. Korth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred L. Tapager-Kirk /wife 3126 Gracefield Road, #113 Silver Spring, MD 20904 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 5/26/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, PA V.150 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive Heart disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner tery Coronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bronchiti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**0 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, certificate has been signed by the rector, page 2 should be detached

Baltimore, Maryland 21215-0036

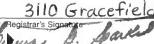
10+

State Registrar

E. S. Machado, MD 31. Date filed (Month, Day, Year) JUN 01 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title



Road

29c. License number

D24035

29d. Date signed (Month, Day, Year) 2010

Silver Spring 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 137 Alexander William William Kaldy, Jr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 🛛 M 2 🗆 F (Month, Day, Year) Hours New Jersey Yrs Director 151-18-6705 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🏋 Yes 2 □ No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1038 Glenwood Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 V Yes 2 □ No If Yes, Give Year or Dates. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanical Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alexander W. Kaldy Julia Csete 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruthann B. Kaldy/Wife 1038 Glenwood Ave., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory: 6/12/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Man Su 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COVONAYY Distust disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner itrial Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Hupertens attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has incommend filled in by the funeral director, page 2 is autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work' 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier

Registrar Qt DHMH 17 Rev 7/2009

DIL

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

121D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WINZHED

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0060336

29d. Date signed (Month, Day, Year)

21740

110110

M D

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOSEPH INVILLE 1:31 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CARROLL HUSPITAL WESTMINSTE CARROLL MD CENTER . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 2, 1954 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 🗆 F Days Min 217-58-7499 56 Mary land Director Usual Residence of Decedent 28a-f shov 10a. State 10h County 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster Maryland 1 🗆 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 849 Snowfall Way 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Car Salesman Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Peterson Marion Linville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Patricia A. Linville, wife 849 Snowfall Way, Westminster, MD 21157 injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important: If ite any injury or ot 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State Screen crematory or other place, 5/28/2010 4 Donation 5 Other (Specify) Winfield, MD Carroll Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home usti 91 Willis Street, Westminster, MD 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strong or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ espirator disease or condition Medical resulting in death) Due to (or s a consequence Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying and I-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 D 9 Unknown been signed by the should be detached g 🔲 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 2 🗌 No this certificate Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner' Hospital Other: 2 YNo 1 Tes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death.

Director: After t
d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29b. Signature and title of certifier DO061558 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD PARIKH 295 STONER AVE, Ste 205 FALGON 31. Date filed (Month, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Reuben R. Levine Month 2010 Medical Mav PM 4b. City, Town, or Location of Death Rockville Examiner Facility Name (if not institution, give street and number) 4c. County of Death 1801 East Jefferson Street T25 Montgomery cial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country)
 PA **Funeral** 089-24-6156 84 Months Days Hours Min 1 X M 2 D F 0/20/11/29/11/9126 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director Montgomery Rockville 1X Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 1801 East Jefferson Street #T25 20852 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clergy Rabbinical 1 and 2 should be filed wit f Health and Mental Hygie item 27 is marked other: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Meyer Levine Sarah Sacks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Daniel J. Levine - son 1112 Churchview Place Rockville MD 20852 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 06/04/2010 Olney, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II/O Rockville Fike Rockville MD 20852 21. Signature of Funeral Service Licenses M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Large Cell Lymphoma disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year ed by the a signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 X No Other: 은 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at thin 24 hours after death.

the Funeral Director: After Impleted filled in by the funeral 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 \( \sup \text{No.} Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl

State Registrar 31. Date filed (Month, Day, Year)

Ralph Vincent Boccia MD 6420 Rockledge Drive Suite 4100 Bethesda MD 20817

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D29675

29d, Date signed (Month, Day, Year)

June 2, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 29 **Physician** 2010 7:30 A M Earlene Byrn Lucas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 1002 Second Ave. Brunswick 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/28/1920 Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 □ M 2 🗓 F Maryland 89 526-30-4872 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the l'edical Evaniner must be notified at 1 X Yes 2 □ No Director Frederick Brunswick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21716 1002 Second Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2No Specify: White Specify ⋛ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lenna Bell Earles Joseph Columbus Barger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health an 1002 Second Ave. Brunswick MD. 21716 Rachel Byrn, Daughter Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brownsville, 6/3/2010 4 Donation 5 Other (Specify) Old Brethren Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Derlace John T Williams Funeral Home, Brunswick MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dise Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 Yo 5 ☐ Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ discar Chromic Obstruction 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No Anome 1 □ Yes 25. Was case referred to medical examiner? ospital or Attending Physician: hours after death. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUNSWICK CHAN-HING 916 610 Year) 32. Registrar's Signature 31. Date filed (Month, Day, State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 29, 2010 Shui Lian Lin 2:00p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Months Hours Min 097037192 88 Yrs **Director** 577-06-6300 China Usual Residence of Decedent 28a-f shov 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No North Potomac Maryland Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11301 Amberlea Farm Drive 20878 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Asian Specify. "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nucai Lin Meinun Li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 2114 Turn Berry Way, Woodstock, Maryland 21163 Qingmin Wang - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 06/05/2010 Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licerse 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. HO # 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Sepsis from Urinary Tract Infection Medical resulting in death) Examiner End Stage Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events End Stage Myelodysplastic Syndrome Months Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ jo in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death the be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by C. Diff. Colitis Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Multidrug Resistant UTI's 24a. Was an autopsy performed Yes 2 Type 2 Diabetes Mellitus 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕰 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

сотріете To the within 2

> Registrar DHMH 17 Rev 7/2009

Suparich RSM NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RSM,

Barbara Sup.
31. Date filed (Month, Day, Year)
11. 02 2010

Barbara Supanich,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD, 1500 Forest Glen Road, Silver Spring,

D 0065485

29d. Date signed (Month, Day, Year)

Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 4:20P 2010 Dolores Liss Medical Mav 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville nder 1 Year | If Under 24 Hrs. Hebrew Home of Greater Washington Montgomery 9. Birthplace (State or Foreign Country) Washington, D If Under 8. Date of Birth Funeral Days 1 🗆 M 2 🗶 F Months Hours (Month, Day, Director 579-36-2272 1931 March Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No <u>Maryland</u> Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 12027 Whippoorwill Ln 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Home Improvement Decorator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Coran <u>Frances Millstein</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mara Consor/Daughter <u>2027 Whippoorwill Ln. Rockville, MD 20852</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem Gardens May 30, 2010 Olney, MD 21. Signaturi of Juneral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line.

ediate Cause (Final assert condition assert condition assert condition) Immediate Cause (Final CANCER WITH METASTASES Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): Physician/Medical o the Hospital or Attending Physician: The law requires that the death certificate being the Funeral Director: After this certificate has hoon somed to the Funeral Director: After this certificate has been somed to the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown page 2 should be detached for Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical pleted filled in by the funeral director, Be 26. Place of Death (Check only one) Division of Vital examiner? Hospital: Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier wellow mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE RD, ROCKVILL Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		Sta	ate of M	larylan		artment of rtificate of			giene Reg. No.	010	18879		
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Examin	er	4a. Facility Name (it	not institution,			'onto	r		or Location of Deat Llstown		4c. C	ounty of Deal			
Funeral		5. Social Security N	lumber	6. Sex 1 <b>X</b> M 2	7. A	ge (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs		th	9. Bir	thplace (State or Foreign		
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eth wit	uner	2463 11. Marital Status	Brent		s Decedent		3, 13,	2121 Was Decedent of H		pecify Yes or No-	-	. S.A.	rican Indian.		
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perm Depa Impo any i		21. Signature of Funeral Service Licersee  22. Hame and Address of Facility uneral Chapel, Inc. 814- Upshur Street, NW D.C. 20011													
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of   1   Ves   2   No   9   Unknown								d. Date of de Month	delivery Day Year				
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ding Phys h. After this funeral dir	ate: To	1 ☐ Yes 2 ☐ 27. Manner of Death 1 ☐ Natural	h 5 🗌 Pendin	28a	1 ☐ Inpat . Date of inju (Month, Da	ury	ER/Outpatie 28b. Time o injury	f 28c. Inju	ry at	Home 5 Residence			patient hospice		
or Atten s after deat I Director: d in by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6  Could r determi	not be	Place of In building, et			reet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,		
n 24 hours n 24 hours re Funeral	Medical	(Check 2	Medical E	xaminer: On t	the basis of	examination	and/or inves	occured at the time stigation, in my opini death occurred at the	ion, death occurred	at the time, date a	nd place, a	nd due to the	cause(s) and manner stated.		
To the within comp.		29b. Signature and	title of certifier	kx M·E	› ·			29c. Licens	D00 57	465	29d. Date:	signed (Mont/	n, Day, Year)		
			·Rajapa	K CP M. I	0,	707	C.	with A	1-, S-2.	35 - Balo	timore	, MD	,21209		
Stat Registra	~	31. Date filed ( <i>Mont</i>	h, Day, Year) N 01 2	010	2. Registr	ar's Signa	ure face	Ked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1816 Physician/ Marta Evelia Larios Mary 28, 02010 Year Medical 4a. Facility Name (if not institution, give street and numbe Washington Adventist **Examiner** City, Town, or Location of Death Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F 46 All 9th, 8 7 1963 Guatemala 217-47-4845 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park MD Montgomery 1 H Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 20912 Guatemala 7600 Maple Avenue #711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ¹™ Yes 2□No Specify: Guatemalan If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nanny Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maria Del Carmen Ruano Santos Ruano Olivares 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Maple Avenue #711 Takoma Park, Md20912 Manuel Larios/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place) Morales, Izabal, Guatemala 1 Burial 2 Cremation 3 Removal from State 6/5/2010 on 5 Other (Specify) 4 Dona 21. Signatur Particular Address RENIALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PRESMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 SOFFICIUMY HEPATIC Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Matastatic Exami executed UAMOUS sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00044957 30 30. Name and address of person who completed cause of death em 23a) (Type, Print) PARK AVE 7600)CARROLL LAGNEW

State

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Rita Petti Landers Physician/  $Ma_{y}^{Month}$  27, 3:00P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 213-92-7713 Days July 31 Year 1944 1 □ M 2 🖺 F 65 Hours Min Italy Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Prince George's College Park 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20740 United States 7310 Baylor Avenue death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Incoronata Braccia Vittorio Alberto Petti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7310 Baylor Avenue College Park, Maryland 20740 John E. Landers- husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 6/1/2010 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a, Part 1, Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ Ovarian Carcinoma with Metastasis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X certificate 2 XNo 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo |요 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) hospice After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28h. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🔲 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60634 May 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu C. 231. Date filed (Month, Day, Year)
WAI 0 1 2010

Registrar DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Road Rockville, Maryland

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:10 p<sup>M</sup> Rosemary E. Myer May 29, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Health 4b. City, Town, or Location of Death Examiner Carroll Lutheran Village Carroll Care Ctr Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 F 14, 1928 Maryland 82 Apr 216-20-1621 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Westminster 1 Yes 2 No Maryland Carroll notified Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a or Examiner must be r 21158 USA 205 St. Mark Way Funeral within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 is marked other than " than Elementary/Secondary (0-12) College (1-4or 5+) College Clerical Work 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Bartholomew Feeney Mary Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Michael Myer, son 548 Lanny Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial Pk 6/2/2010 Sykesville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 28a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the 1 as attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 mont 1 Yes 2 No Month ģ Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? 1 ☐ Yes this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Inpatient ဥ 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Prink)

M. PANSURIYA 349 Malcolm DR 32. Registrar's Signature

D 51705

29d. Date signed (Month, Day, Year)

westminster,

06-01-2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:10am Blodwyn Elizabeth Marsh (AKA) Bonnie E. Marsh 2010 Mau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Arcola Nursing Home Silver Spring 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 28. 1919 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 X F Hours Pennsylvania Director 579-09-6309 91 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 310 Colesville Manor Drive u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc ð 1 Never Married 2 X Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", If Yes. Give White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Prince George's College (1-4 or 5+) Elementary/Seconday (0-12) Librarian Assistant Library System Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည Florence Turgeon David Everett Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant: If item 27 is y injury or other trau 310 Colesville Manor Drive, Silver Spring, MD 20904 Clayton C. Marsh - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. of 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Lincoln Crematory 06/03/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee MO # 1070 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enterthed isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. nterval Between Onset and Death Minutes Immediate Cause (Final -Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗓 No Month Veal Day Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig page 2 should b Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🗶 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) ပ္ 0 June 2, 2010 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3720 Farragut Avenue, Kensington, Maryland 20895 Barry Rosenbaum, 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

JUN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month <sup>D</sup>2010 Physician/ Robert Francis Mersdorf 29 10:05P. м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3156 Gracefield Road, #101 Prince George's Silver Spring 5. Social Security Numbe 359–05–4842 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours May Year 921 88 New York **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Prince George's Silver Spring 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o edical Examiner must be Funeral 20904 3156 Gracefield Road, #101 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White If Yes, Give Completed 3X Widowed 4 □ Divorced Year or Dates. WWII . Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natui jury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0.12) College (1-4 or 5+) Information Technology Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Bubel Raymond C. Mersdorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen A. Mersdorf -daughter 8780 Sage Brush Way Columbia, Maryland 21045 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 6/3/2010 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses Donald AvesBorgwardt Funeral Home, PA UB 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Months shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Metastatic Adenocarcinoma of unknown primary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown detached g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary artery disease; Type II Diabetes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2. No death? certificate 1 ☐ Yes 2 🗓 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\stackrel{K}{X}$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ျှ June 3, 2010 D43237 liate 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive, #102 Laurel, Maryland 20707

Registrar

State

31. Date filed (Month, Day, Year)

JUN 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>7:50</u> Pм Ethel M. McBride 2010 Medical Tune 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice/ Casey House Montgomery <u>Rockville</u> If Under 1 Year Months Days 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Hours (Month, Day, Year) L0/16/1916 9.3 Yrs Director 077-12-7456 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No 01ney MD Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral .8301 Georgia Ave 20832 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Force Black, White, etc. Be Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christian Rohrbach <u>Emma Augusta</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Ford / Daughter Round Leaf Way Gaithersburg, MD 20879 Department of Heali Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Island Nat. Cemmi 06/09/2010 | Farmingdale, NY Long Signature of Funer L revice Licenses 22. Name and Address of Facility Danzansky-Goldburg Memorial Chapels 1170 Rockville Pike Rockville, MD 20 MO1477 ⊘Kurt Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Cerebrovascular Accident Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate outse. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year Other (specify) 9 Unknown 9 Unknown ate has been sign**e**d by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed Hypertention 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available 24a. Was an <u>Hyperlipidemia</u> autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 7/2009

State

Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

<u>Jocelyn Kouatchou M.D.</u>

04

Jocelyne Kouchehou, mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D63747

East University Parkway Baltimore, MD 21218

29d. Date signed (Month, Day, Year)

June 02, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** George Duncan MacMillan, Jr. May 28. 2010 10:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5311 Concord Court Mount Airy Frederick If Under 1 Year Months Days Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Hours Director 147-28-0859 1939 New York 71 March 16, Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examination at he notified at 1 □Yes 2 No Director Maryland Frederick Mount Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21771 USA Funeral 5311 Concord Court within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:1961-65 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 💆 No Specify. \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) <u>self-employed</u> Specifications is marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should b of Health and Ment item 27 is marked George Duncan MacMillan, Sr. Helen Shofstal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Rosemarie MacMillan, wife 5311 Concord Court, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation Metropolitan Crematory 5/29/2010 | Alexandria, Virginia 21. Signature of Fu eral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause on each line. Immediate Cau e (Final disease or cond tio resulting in deat **Physician** Cardrac 50 >able /Medical Due to (or as a consequence of): Examiner Cardio Myora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 2 □No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔼 Natural death. 1 ☐ Yes 2 ☐ No after death

Director: 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft: To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

6tIVA State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shar

JUN

Hemen

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Can mark

29c. License number

D6041

29d. Date signed (Month. Dav. Year)

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Date of Birth (Month, Pay, 9. Birthplace (State or Foreign **Funeral** Year) 920 Min. X M 2 F 90 Months Days Hours 161-16-3730 Pennsylvania **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Bushwood St. Mary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22455 Bushwood Rd. 20618 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 x Widowed 4 Divorced Specify: White Completed WWII Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Claims Examiner U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph F. Maddox Margaret Omlar . Page 1 and 2 shoument of Health and tant: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22455 Bushwood Rd., Bushwood, Brenda Ellwood Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) June 2 Daty Old Durham Episcopal Church 20a. Method of Disposition 20c. Location - City or Town, State 2. Date 2010 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ironsides, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service €icense Williams Funeral Home, 4270 Hawthorne Rd., In M00668 Indian Head. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 1014 Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last l physician a s the burial⁴ Physician/Medical Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Day Pregnant at time of death signed by the a 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No this certificate has page 2 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funera. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person NaO avakul, 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JUN U 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 30, 2010 12:05 A M Moody Robert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6716 Larkspur Road Prince George's Morningside 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maine 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Hours May 16, 1933 77 002-22-7472 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Morningside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6716 Larkspur Road 20746 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married ρ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.

7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ret Airforce DeFense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lyman Moody Goldie E. McSorlev other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scarlett Moody (Wife) 6716 Larkspur Road, Morningside, MD 20746 Baltimore, 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery June 8, 2010 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee MY G Ferry Road, Clinton, MD20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Neoplasm, Lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rit any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 A No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deatler Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

JUN 03

Dr. Ivan Zama, MD 9200 Basil Court, Ste 200, Largo, MD 20774

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death **Physician** NARITUN MCNUH 730 A /Medical ion, give street and nymber) Valley Nuv 4b. City, Town, or Location of Death **Examiner** Kockvill Montgomen 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 05 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F Days Hours 043-30-9821 72 Director CTUsual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28s-f ehow other traumatic event, the Macdical Examinar must be notified at 1 ☐ Yes 2 🕅 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5800 Genesis Lane 21703 u.s.A. death Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other there only injury or other traumers. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No þ Specify. 3 ☐ Widowed 4 🎇 Divorced Specify Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker 4 U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Brunnoch Kathryn Burr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea J. Sloan - Guardian 1350 Beverly Dr., Ste 115-232, McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Martitavia Nationate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/28/2010 Laurel, Maryland Memorial Park 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** 1 week pneumonia /Medical Due to (or as a consequence of) Examiner espiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and d be detached for use as the burial-transit tailure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 🗆 Yes 3 Probably 4 Unknown Sychosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an anovetia 1 ☐ Yes To the Hospital or Attending Physicism: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) From who completed cause of death (Item 23a) (Type, Print) Molecular Drive#201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25<sup>Day</sup> May 2010<sup>ar</sup> Mark 7:35A. M Mvers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Apple Blossom Assisted Living Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 186-20-0653 1 □ M 2 🖫 F 92 Days Hours JULY 27, 1917 Director Pennsylvania Heual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Maryland Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1013 Cresthaven Drive 20903 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Washington Pennsylvania (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) School Teacher Schools permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Desse Huffman David Walter Myers 19a. Informant's Name/Relation (Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3118 Kilkenny Street Silver Spring, Maryland 20904 Suzanne Mark -daughter 20a. Method of Disposition
1 

Burial 2 

Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 5/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service License 2Donald Advess Borgwardt Funeral Home, PA Wonald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINUTES Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Malnutrition 2-3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Anorexia 3-4 months that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical End Stage Parkinsons Disease 2 years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia; Urinary Retention; Deep Vein Thrombosis -1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? left leg; History of Breast Cancer 24a. Was an certificate has be irector, page 2 s performed? Yes 2 No 2 X No 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother assisted lvng. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) MD 00032654 8 May 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar John Serlemitsos, M.D.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

2033 Penderbrooke\_Drive Crownsville, Maryland 21032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 3:30р м Trinh Nghieu Nguy 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8634 11th Avenue Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours 1470271925 218-94-8165 84 Vietnam Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral 20903 U.S.A. 8634 11th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕱 No Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes Give Specify. 3 Widowed 4 Divorced Completed Asian Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Computer Services Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Data Entry Clerk Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ngoc Tran Quingoc Nguy Sung Duc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Maryland 20903 Phuong Ly Nguy - Spouse 8634 11th Avenue. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Pk. 06/09/2010 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. /23 z H1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Coronary Artery Disease years disease or condition Medical resulting in death) Examiner Advanced Congestive Heart Failure 5 uears Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 2 No Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: 4 Nursing Home 5 🗶 Residence 6 🗆 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 2 June 03, 2010 D21900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Ho, MD, #280. Takoma Park, Maryland 20912 7610 Carroll Avenue.

State Registrar 31. Date filed (Month, Day, Year)
JUN 0 4 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9, 0445 Phyllis M. Notson lai 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Alisbury Rehab + Nursing Social Security Number 6. Sex Wicomico oulisbur If Under 1 Year | If Under 24 Hrs s. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. 479-28-9805 81 Dec. 26, Director 1928 Iowa Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ? is marked other than "natural", or items 23a or 28a-f show traumatic event, It w Medical Example or most be molified at Director 1 ☐ Yes 2X No Wicomico Salisbury MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 U.S.A. 346 Troopers Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian. 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it at Medical Evan, it as once. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 2 If Yes, Give Year or Dates: Specify: white 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della Goodner Bird O. Rice ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 Salisbury, MD (Daughter) 8406 Hilda Drive Donna Jacobs 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 2,2010 Crematory of Delmarva Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part 1. En er the discase, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail are. List only one cause such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 70200 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use es the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Be Certification: To funeral

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, the cate has been signed by page 2 should be detach certificate has After this neral Director: A filled in by the fi within 24 hours a

To the Funeral C

completely filled

death with the Maryland

Maryland 21215-0036

Baltimore,

		24a. Was an autopsy findings availab prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No									
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred 2 \[ \] No									
3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of my knowledge, death occurred at the time, daininer: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and due to the cause(s) and manner as stated. , death occurred at the time, date and place, and due to the cause(s)									

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

cal

29b. Signature and title of certifier

JUN O

Milliam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Teresa Maria Naranjo May 1:07 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year, May 19, 1 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) Ecuador 1 🗌 M 2 🛣 F Director 212-31-3900 88 1922 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18720 Capella Lane 20877 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 🕱 Yes 2 □ No Specify: Ecuador Specify: Other "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filled within 72 ment of Health and Mental Hygiene ant; If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 0 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agustin Vergara Carmen Abad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Magdalena Naranjo, Daughter 67 Portside Ct. Gaithersburg, MD 20877 permit. Page 1 and 2 Department of Health Important; If item 2; any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 x Cremation 3 Removal from State Ft. Lincoln Crematory 6/1/2010 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. In order the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (Final Cardiac Arrhythmia Approximate Interval Between Onset and Death Cardiac Arrhythmia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pericardial Effusion Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami Hypotension that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Renal Failure Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown signed by the a 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown page 2 should Gastric Cancer 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? performed? Coronary Artery Disease 1 Yes 2 No Yes 2 W N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔼 No မ 1 Inpatient 2 K ER/Outpatient 3 I DOA 24 hours after death.
Funeral Director: After thi eted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

V. Ganti, MD 19529 Doctor's Drive Germantown, MD 20874

29c. License number

D41162 MD

29d. Date signed (Month, Day, Year)

May 25, 2010

Luis Ravanales Hamington Orozco

10-04064 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Unk Unk

		1- For State Certificate of Death Registrar	Reg. No. 2010 009										
Physici I Exami		Hamington Luis Ravanales Orozco	Date of Death Month Day Year May 27, 2010  3. Time of Death 2111 hrs										
		4a. Facility Name (if not institution, give street and number)  Suburban Hospital  4b. City, Town, or Location of Death Bethesda	4c. County of Death  Montgomery										
uneral rector		none 27 Months Days Hours Min.	3. Date of Birth(MMDD/YYYY) 9. 8 inthplace (State or Foreign Gounty) uatemal										
show any ICE.	or	Usual Residence of Decedent  10a. State	10d. Inside City Limits 1 Yes 2 No										
s 23a or 28a-f show a e notified at once.	Director	2100 Dexter Avenue Apt.201 10f. Zip Code 20902	10g. Citizen of What Country? Guatemala										
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funel	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No  13. Was Decedent of Hispanic Origin? (Specific Fig. 1) Specify: 13. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 13. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 13. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 13. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 14. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 14. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 14. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 14. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specify: 14. Was Decedent of Hispanic Origin? (Specific Fig. 2) No Specific Fig. 2) No Specific Fig. 2 No Specific Fig. 2 No Specific Fig. 2 No Specific Fig. 2 No Specific Fig. 2 No Specific Fig. 3 No	can, etc.) White, etc.										
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ntal Hygiene. rked other than ' ent, the Medical	Be	Milton Rodolfo Ravanales Miriam	rst, Middle, Maiden Surname) Margot Orozco										
th and Me 27 is ma umatic ev	To		t.21 Silver Spring Md										
ment of Heal tant: If item or other tra		20a. Method of Disposition  1 Aburial 2 Cremation 3 Removal from State Dongton 5 Other Steelify:  20b. Place of Disposition (Name of cemetery, Parentee of protein the parentee of place of Disposition (Name of cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemetery, Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Disposition (Name of Cemeter), Parentee of Dispositi	San Marcos, Guaten										
Depart Impor injury	0.3	My While 9241 Columbia Bly	FUNERAL SERVICE, P.A. vd.Silver Spring, Md2091										
sician oʻ miner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):	spiratory arrest, shock, or heart Approximate Interval Between Onset and Death										
sit	Examiner	Sequentially list conditions, b											
physician and the burial - transit	Medical E	UNPENDED AMENDED											
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  5 Other (Specify)  9 Unknown	23d. Date of delivery Month Day Year										
signed by the	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown										
ate has been si age 2 should b	Completed		24a. Was an autopsy performed?  1 V Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?										
s certificate irector, page	Be	25. Was case referred to medical examiner?  1											
eath. tor: After this the funeral dir	ition: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  FOUND:  28b. Time of Injury 28c. Injury at Work?  FOUND:  1 Yes 2 No	d. Describe how injury occurred bject shot										
within 24 hours after de To the Funeral Direct completely filled in by 1	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f	f. Location (Street and Number or Rural Route Number, City or Town, State) orgia Ave @ Dexter Ave, Silver Spring, MD										
within 24 i To the Fu completely	Medical	Check only one)  2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.											
5 F 3	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)										
,		30, Name and address of person who completed cause of death (Item 23a)	May 28, 2010										

OCME

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, Completed by of Vital 25. Was case referred to medical examiner? Be 1 Yes 25 No Medical Certification: To funeral 27. Manner of Death After Division Natural within 24 hours after death.

To the Funeral Director; A 2/ Accident in by the 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Nurse Practioner 29b. Signatu 29c. License number 2126363 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 Went CANP 31. Date filed (Month, Day, 32. Registrar's Signature State **JUN 01** Registrar DHMH 17 Rev 1/2001

**Physician** 

/Medical

**Examiner** 

Funeral

**Director** 

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"natural", or items 23a

Director

Funeral

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Completed

other traumatic event, the Medical Examinar must be notified at

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			For State	State of M	aryland	-	rtment of F tificate of				iene <sub>eg. No</sub>	10	18896
			Registrar  1. Decedent's Name (First, Midd	dle, Last)						Date of Deat	The same of	10	3. Time of Death
	Physic		DAICY	F PRAT	T					Month	Day	Year	1148 M
and !	/Medi Examir		4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death		4c. County		77 . 0
			Washington Adv	entist Hospit	tal		Takoma 1	Park			Monte	gomer	У
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthp Cour	lace (State or Foreign htry)
	Director		217-30-7058 Usual Residence of Decedent	1 L M 2 23 1	78	Yrs.				2/09/1	.932		DC
	land ow		10a. State 10b. County	у	10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	Many a-f sh	햦	DC		Wash	ingto	n						1 ∭XYes 2 □ No
	or 28	Director	10e. Street and Number		1100011	211900	10f. Zip Code			1	0g. Citizen of	What Coun	try?
	23a (	a L	1050 New Jerse	y Avenue, NW			20001				USA		
	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Or an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)		ce - Americ	
36	s afte	by F	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	No		□Yes 2XINo				Specif	y: Bla	al.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Mudical Evertines he notified at	ed		d Year or Dates:		16a. Deced	ent's Usual Occup	ation			 16b. Kind of B		
215	in 72	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)		(Give I	kind of work done O NOT use retired	durina mos	t of working	1			,
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pu	be filed tal Hygi d other event, t	Be (	17. Father's Name (First, Middle	, Last)							Aaiden Surnan	ne)	
yla	should be f and Mental I s marked of umatic eve	၉	Richard Pratt					Mary	Alice	Thorn	ton		
Maryland	2 sho and l		19a. Informant's Name/Relation		I		g Address (Street				-		Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evanriner must be notified at		Shirley A. Lay 20a. Method of Disposition	- sister			Street,		Wasnin		20c. Location		wn State
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		1 ☑XBurial 2 ☐ Cremation				sition (Name of atory or other place	1				•	
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	/Medical		disease or condition resulting in death)	a. Due to (or as			MOONS	77)					
	Examiner		Sequentially list conditions	b. ———	1	0							
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3	and I-tran	Examin	that initiated events resulting in death) Last	c Due to (or as	a consequer	nce of):						-	
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œ.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify) _	;y 			Mo	onth	Day Year
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Ś	The law requires that the death cer ate has been signed by the attendin age 2 should be detached for use	ρ	Part II. Other significant condit	Ω		ng in the un	derlying cause giv	en in Part I					ne cause of death?
orc	w requir been s should	ted	Approx	es Inily	nemi	a			1	1 ∐ Ye	s 2 No	3∐ Prob	ably 4 Unknown
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of Vital Records,	ician: The L certificate ha ector, page									perform 1 □ Yes 2	No No	death? 1 🗆 Yes	2 □ No
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on	nding Ph tth. :: After th e funeral	ţi	1 Natural 5 Pendii 2 Accident invest	ng (Month, Da tigation	y, Year)	Injury	Worl	k? Yes 2□			. ,		
Division	or Attending after death. Director: Afte in by the fune	iji	3 Suicide 6 Could 4 Homicide detern		ury - At home	e, farm, stre	et, factory, office		28f.	Location (St.	reet and Numb	er or Rura	I Route Number,
Ö	tal or rs afte al Dir led in	Certification:	4 Directions		c. (Opecity)					City of Town	, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medica	ing Physician: To the best									
	To the P within 2 To the P complet	Medical	one)	and manner sta			29c. Licens				9d. Date signe		
	UI SEE		29b. Signature and title of certified	achi leas, A	AD		_	6370	2)3	2	C) (10	21 11	)
	10		30. Name and address of person			3a) (Tupo F	_		CACI	2074	AVEL	2118	
			SABYASAC		oun (nom Z	o⊸, ∖iype, F			LA P		MD	~ ~	-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret Lynne Phifer 7:20 am 2010 Mau Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Bedford Court Nursing Home Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕮 F Months Days Hours Min 0170271937 Director Yrs Washington. DC 577-50-8463 Usual Residence of Decedent 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13204 Betty Lane 20904 u.s.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō, ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 Tes 2 No Specify: "natural", Specify Caucasian Completed 3 X Widowed 4 ☐ Divorced the Medical 15, Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry teath and Mental Hygiene.
n 27 is marked other than "n y traumatic event" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. ပ James Thomas Duff Margaret Coles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Hines Phifer, III - Son 4813 Timber Drive, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of 06/15/2010 Silver Spring, Heaven Cem. 21. Signature Fun 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Non Small Cell Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ur as a cullsequence ul) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown for Month Day Year page 2 should be detached 9 🔲 Unknown ed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 X Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed death? 2 🗌 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature D35635 June 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, MD, 18111 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) State JUN 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ they Month Day 2010 2/30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cross Burtonsville anctuary@ itoly Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 D F Days Min. Dec. 20, 1925 Hours 578-22-4978 84 Worth Carolina Director Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Fulton Maryland Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 9443 Ellsworth Court 20759 USA items ; within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: WWII era "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Package Delivery 11 Special Police permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other t any injury or other traumatic and the Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Carl Lee Peninger, Sr. Addelle Hazel Cuthbertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mancini Peninger/Wife 9443 Ellsworth Court, Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Gate of Heaven Cemetery 2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service Licens <sup>22</sup>Francis die Colinia Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Sterroma Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No Yes 1 ☐ Yes To the Hospital or Attending Physician: **Division of Vital** To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No I Director: / Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QVI E

Registrar
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## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medica Examine	_	Irvin W. Pri 4a. Facility Name (if not insti			per)		4b. City, Town, or	Location	of Death	May 26	· —	County of De	12:15 eath	) A "	
		Northampton					Frede				Frederick				
Funeral Director		5. Social Security Number  146-18-7323  Usual Residence of Decede		M 2 □ F	7. Age (In yrs. la	ast birthday)  S Yrs.	If Under 1 Year Months Days	If Under Hours		8, Date of Birt (Month, Day Aug. 3,		4 Ma	Birthplace (State of Country) aryLand	r Foreign	
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in 24 hour her file file file file file file file file	Medical	(Check 2 Med only one) 3 Cert	ical Examine ifying Nurse I	r. On the basis	s of examination	and/or invest	ccured at the time, igation, in my opinio leath occurred at the	n, death o	curred at	the time, date a	nd place, a	and due to th	e cause(s) and ma	nner stated.	
To t										c. License number D 576 4 3 29d. Date signed (Month, Day, Year) 572 7/10					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year RUEL PM 4:46 Renee 2010 Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bolthmore Medical University of Mongland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕸 Country Delaware Months Davs Hours Aug. 16, Year)1963 Director 217-86-5765 46 Usual Residence of Decedent fshow Page 1 and Should be fled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Caroline Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21636 15200 Jarrell Road U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceud. Armed Forces? ✓ Yes 2 No 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Pete Porter, Sr. Ruth Ann Kenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moranda Lynne Ostrander, daughter15200 Jarrell Road, Goldsboro, Maryland 21636 Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Greensboro Cemetery June 8,2010 Greensboro, Maryland Signatury of Funeral Service Licensee 22 Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA Sunset Ave., 21639 Greensboro. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical disease or condition resulting in death) Interstick Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate number of the conditions Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has I autopsy performe After this certificate 25. Was case referred to rical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) universit Bottemore MET S. Greene St., 32. Registrar's Signature State

**ORIGINAL** 

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ JAMES DRYDEN PAYNE, SR. Day 29, 2010 8:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death DENTON, MARYLAND CAROLINE ENVOY HEALTHCARE 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** FEB I5 Days Hours 216-40-4122 74 Director 1936 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits RHODESDALE DORCHESTER MD 1 ☐ Yes 2x ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21659 UNITED STATES 5726 COKESBURY ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) GRAIN, POULTRY Elementary/Seconday (0-12) College (1-4 or 5+) FARMER TRUCK FARMING 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GILBERT PAYNE, SR. MINNIE BRINSFIELD 19a. Informant's Name/Relationship (Type, Print)  $^{19b.\ Mailling}$  Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5821\ LONE\ PINE\ RD$  , RHODES DALE , MD  $^{21659}$ JAMES D. PAYNE, JR./SON 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State SHORE CREM.CTR 6/4/2010 CAMBRIDGE, MD MID 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FRAMPTOM FUNERAL HOME, FEDERALSBURG, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onse and Dea Physician/ DEMEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy death? perform Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 🕅 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28b, Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Medical 29a. Certifier f 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifie TTENDING MIN 1-Name and address of person 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Charles Wesley Peterson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

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Medical Examir	ier	CHARLES V	WESLEY	PETER	SON					May 27,	2010			0610 hr	S
		4a. Facility Name (if not institution 6711 Bailey Store Ro		umber)		4	4b. City, Town, o Federalsbu		of Death			county of orcheste			
Funeral	7	5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday	y)	If Under 1 Yes	ar If Unc	ler 24Hrs.	8. Date of I	Birth (MM/D	n(MM/DD/YYYY) 9. Birthplace (State or			or
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	t	Usual Residence of Decedent													
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Maryland 28a-f show any <u>d at once.</u>	5	MD Dore	chester			F	ederal	sbur	g					1 Yes	2 X No
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ME and 2 s and 27 m 27 wum:	1	Christine A 20a, Method of Disposition	<u>. Lankic</u>				Prest			urio Date				own, State	
Baltimore, MD 2121, permit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	1	1 X Burial 2 Cremation	n 3 Removal f	rom State	crematory of	or oth	ner place)						Ť		
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Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Gunshot V			Leg	3						_		
	-	Sequentially list conditions,	b.		,-										
	힐	if any, leading to immediate	Due to (or as	a consequenc	ce of):										
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ansit	events resulting in death) Last  Due to (or as a consequence of).  d.  UNPENDED  AMENDED  IF FEMALE:  23d. Date of delivery  Month  Month  Month														
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687 ertific ding p	an/	23b. Was decedent pregnant in to past 12 months?	I I I I I I I I I I I I I I I I I I I		2	4	tal death 3	Ectop	ic pregnanc	y	_ N	/lonth	D	ay `	Year
Box 68 e death certi the attendin	Physicia	1 Yes 2 No 9 Un	iknown 9 Unkn	nant at time o	5	Oth	her (Specify)								
D. B the d	튑	Part II. Other significant condi-			ot resulting in	the u	nderlying cause	given in P	art I.	23e. Did	tobacco us	se contrib	ute to t	ne cause of d	leath?
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/ital   ysician: nis certifi director,	8	examiner?	Hospital:	Inpatient 2	ER/Outpa	tient		Other <sub>4</sub>	Nursing I		Residen	ce 6 🗸	Other:	Scene	
of Vital Records, ing Physician: The law requir After this certificate has been submeral director, page 2 should land.	의	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time			ury at Wor			e how injur	y occurre	<u>d</u>		
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Division of You the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After the Completedy filled in by the funeral		29a. Certifier 1 Certifying P	Physician: To the be												
To the within To the compl	Medical		aminer:On the basis and manner		on and/or inves	stigat				ne time, da					
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		Name and address of person Laron Locke MD.	n who completed 🕬 Assistant Medic			enn	Street, Balti	imore N	AD 21201	1					
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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2 Day Physician/ 05 Year 1904P M Virginia Julia Purnell 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HIGMICO REGIONAL ENINSULA SAUSBUU Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min (Month, Day, Year) Ct. 11, 1921 88 214-16-4396 Director Mary land Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a USA 21811 7937 E. Shire Drive Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Commander Hotel Housekeeping 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lemuel Henry Holland Lydia Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7937 E. Shire Drive - Berlin, Maryland 21811 Ozella P. Williams / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: It any injury or Williams AME Church Cem. | 06/04/2010 Newark, MD 4 Donation 5 Other (Specify) permit. Signature of Funeral Service License Salisbury, 22. Name and Address of Facility 1213 Jersey Road 21801 Jolley Memorial Chapel -23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Dreumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hemorrhay Intra eronial Sequentially list conditions, constituence of cause. Enter Underlying Cause (Disease or linjury Exami executed Uninary nacr in fection sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 🗌 Yes Completed 2 No 3 Probably 4 Lillinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D68222 05-27-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) / m Salisbury MO 2180,

State Registr<u>ar</u> 32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 9:00 PM Dana Lynn Peterson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll 5105 Biemiller Rd. Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 19<u>58</u> Hours oct. 15, 1 □ M 2 🔀 F Months Min North Carolina Director Yrs. 213-50-8177 Usual Residence of Decedent shov 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 5105 Biemiller Rd. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, r than "natural", or ite the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates. ρ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Marada Industries Human Resources Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ Elton M. Peterson Zona Yarboro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Elton M. Peterson/Father 5105 Biemiller Rd., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of EXECUTE: Or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 27, 2010 Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee 22 Pritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, Md 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod y if dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on e Immediate Cause (Final Set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to mind a cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician stached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autops perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 24 hours after death.

Funeral Director; After this leted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 P Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier 🚊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death 3:30AM **Physician** 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 7. Age (In yas. la Prince lashington MShinton (seurce If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (S If Under 1 Year Social Security Number . last birthday **Funeral** Days 3 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at ulalclof 1 Yes 2 No Director MARZIAN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 20603 or items 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exercises. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Skilled WSSC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ MAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. P MI) 20640 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location -20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e and Address of Facility Funeral Service I 2060 Appr ximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Conge heart **Physician** nknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for es a ponsequença offi if any, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗫 o Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 MER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier 25 5569 2010 MO30. Name and address of person who completed cause of death [Item 23a) (Type, Print) 20744 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Barbara Petes May th 31, 2010 Year 5:15 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Content York Days 1 🗆 M 2 🕱 F Months Hours 132-16-0255 88 Sept. 14, Year921 Director Usual Residence of Deceden ıral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland Director 10a, State 10b Counts 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3711 Leverton Street 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 KokWidowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Loan Manager Banking/Financial permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Szalancy Susan Olah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda C. Cawley/Daughter 3711 Leverton Street, Silver Spring, MD 20906 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Opter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition cerebrougeculor Medical resulting in death) Due to (or as a consequence of): Examiner Floribria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence oil) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Other (specify) Month Day signed by the a Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 🗆 No Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.
To the Funeral Director: After this confidence of the funeral prince of the funeral p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 069916 of person who completed cause of death (Item 23a) (Type, Print) NIOK Forest Date filed (Month) Registrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayont 30, Physician/ Year 2010 3:00 a Sally Hobbs Pratt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day ) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏞 F Months Days . 19<u>21</u> 88 Maryland 215-18-3026 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Montgomery Silver Spring 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 20902 USA 4006 Adams Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White ¾¥ Widowed 4 □ Divorced Completed Year or Dates er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) n 27 is marked other than vertraumatic event Elementary/Seconday (0-12) College (1-4 or 5+) Retail Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eleanor Cissel Charles Wesley Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12908 Old Columbia Pike, Silver Spring, MD 20904 Roger Pratt/Son : If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date May 3 2010 permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 31 cemetery, crematory or other place)
Metropolitan Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Francis Address Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Euneral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Acute Stroke Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertensive Urgency Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-transit Atrial Fibrillation and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ed by the a detached f 1 L Yes 2 L 9 L Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown certificate has been si rector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death?

1 Yes 2 No 24 hours after death.

3 Funeral Director: After this certific leted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗷 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) May 31, 2010 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Compatible Alagarsamy, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) **JUN 01 2010** 

			Please Type or Print in Blac State of Maryland / I	Department of Health and M								
		•	For State State Registrar	Certificate of Death	Reg.							
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Solomon Pekar		2. Date of Death Month May 2	29, 2010 3. Time of Death 8:50p M						
٠,	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 2	4c. County of Death						
-			Hebrew Home of Greater Washington			Montgomery						
	Funeral Director		213-37-7800	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea May 08, 1	9. Birthplace (State or Foreign Country) Ukraine						
	Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Maryland Montgomery	n or Location  Rockville		10d. Inside City Limits 1 ☐ Yes 2 🔯 No						
	with the 23a or 3ust be n	eral D	10e. Street and Number  12620 Veirs Mill Road, #311	10f. Zip Code 20853	10g.	g. Citizen of What Country? U.S.A.						
920	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene.  the mand Mental Hygiene.  them 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a nor 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>چ</u>	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
21215-0036	72 hou in "natu Medical	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	ng 16t	b. Kind of Business Industry						
	within rgiene. ner tha t, the I		Elementary/Seconday (0-12) College (1-4 or 5+)	Journalist		Journalism						
Maryland	should be filed within and Mental Hygiene. is marked other tha 'aumatic event, the N	To Be	17. Father's Name (First, Middle, Last)  Moshe Pekar		e (First, Middle, Maid Rozaliya	den Surname) (Unknown)						
Man	2 shoul th and 27 is m traums			o. Mailing Address (Street and Number or Rura 1620 Veirs Mill Road,								
	permit. Page 1 and 2 s Department of Health . Important: If item 27 any injury or other tra once.		20a. Method of Disposition 20b. Place o			c. Location - City or Town, State						
Baltimore,				wn Memorial Pk. 06/0	1/2010 R	ockville, Maryland						
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee  MD0709	11800 New Hampshire	Ave., Si	li Funeral Home, Inc. lver Spring, MD 20904						
	Physician/ Medical		23a. Part 1. Enter the dilease, or complications that caused the death. Do not shock, or hear that it is List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the consequence of th	ia	or respiratory arrest,	Approximate Interval Between Onset and Death						
P	be executed itsian and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a consequence of the condition of th	·		Over 5 year						
× 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici ted filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	d	h 3  ☐ Ectopic pregnancy		23d. Date of delivery						
. Box	he death y the att ched for	hysici	in the past 12 months?  1  Yes 2 No 9 Unknown	5 Other (specify)		Month Day Year						
ls, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?						
Records,	Physician: The law req or this certificate has bee aral director, page 2 shoi	Completed	Vasulas dementia		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No						
of Vital	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/0	26. Place of Death (Check		a C C Other (Secsifi)						
of V	ding Phys h. After this funeral di	te: To	27. Manner of Death 28a. Date of injury 28b.		28d. Describe how i	e 6 Other (Specify)						
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fur	Certificate:	1 Natural 5 Pending (Nonth, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	M 1 Yes 2 No							
Δ	To the Hospital or Attent within 24 hours after deati To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Examiner: On the basis of examination and/o	ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the within 2 To the comple	-	29b. Signature and title of cartifier (Benso	29c. License number		Date signed (Month, Day, Year)						
	2		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) / 1NOA O. Ban	USON, M.D	250110						
	-01-	10	31. Date filed (Manth, Day, Year) 32. Registrar's Signature	KOCKINIE /11-	U 20	852						
	Sta Registr		JUN 01 2010 Centra A.	parle								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ T2 20 T0 JÜÑE BARBARA ROSE PERRIE 8:00AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6820 GRAYMAR LANE PORT TOBACCO CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea SEP 20 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Year) 1 M 2 X F Director 215-74-8004 78 MARYLAND Usual Residence of Decedent 28a-f shor Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD CHARLES PORT TOBACCO 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6820 GRAYMAR LANE 20677 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify WHITE 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRAINEE MELWOOD 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ည NELSON HUTCHINSON PERRIE MILDRED ANITA TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA G. BOSWELL/NIECE 16335 TANYARD RD. UPPER MARLBORO, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of JUN¶te 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State IMMANUEL CH.CEM. 17,2010 BADEN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P. A Signature of Funeral Service Licensee Barton M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Coun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Immediate Cause (Final ERKBRAN Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner x wks ONGRITTVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed INGESKY Mari attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performe death? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Other: ျ 4 ☐ Nursing Home 5 ☐ Residence 6 🗙 Other (Specify) GCOUPHO 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fi Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hour, to the Funeral Diccompleted filler Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar and address of per

31. Date filed (Mark)

YEURER

5 Dr MO

NALDORG-MI

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WATZISON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Carol D, Rottman 29 2010 May 8:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 26, 1936 6. Sex **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Months Min. 1 🗆 M 2 💢 F Hours Mary Land **Director** 213**–**32**–**5451 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>303 Redland Blvd. Apt #205</u> 20850 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces ò Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than econday (0-12) College (1-4 or 5+) Long and Foster Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth Davis Duke Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trac 303 Redland Blvd. Apt #205, Rockville, Maryland Ellis Rottman/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 22. Name and Add Danzansky-Goldberg Memorial Chapels, Inc 21. Signature of Funeral Service Licensee M01597 Melissa C. Greenhut 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Colon Cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of); Examiner Lung Metastasis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte be detached for Year Month Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Kes 2 □ No 3 □ Probably 4 □ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 🗌 Yes 2 🔀 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical A certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Gentifying Nurse Practioner: To the best of my knowledge, death pround at the time, date and place, and duri to the cause(s) and manner as stated ignature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swann MD 1396 Piccard Drive Rockville MD 20850 Sandra L.

DHMH 17 Rev 7/2009

State

Registra

31, Date filed (Month, Day, Year)

**JUN 04** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esther Marie Rhoderick  $\mathbf{P}^{M}$ May 2010 8:06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Carrol1 Westminster 5. Social Security Number If Under 1 Year If Under 8. Date of Birth (Month, Day, Nov. 8, 6. Sex . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 і 🗆 F Months Days Hours Min. Director T933 Pennsylvania 171-28-2809 76 Nov. Usual Residence of Decedent show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9936 Moxley Road 20872 death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Worker Restauant/Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Amos Emanuel Hykes Alice Marie Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold L. Rhoderick, husband 9936 Moxley Road, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Providence Methodist Cem. 6/2/2010 Monrovia, Maryland vice Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home . Signature of Fureral S yau 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that claused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or constitution) sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Ph, sician/ disease or cor Medical resulting in death) Due to (or as a consequence of) Examiner Clepro Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or) 2 that the death certificate be executed and-tran Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnape 23d. Date of delivery Ectopic pregnancy in the past 12 months Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 No g Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy perform 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? 1 Tyes 2 1 Other: 4 Nursing Home 5 Residence 6 Dother (Specify) DOVE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of HOWE 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 24 hours after death Funeral Director: A 1 Tes 2 No Accident the Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

To the 1 within 2 To the 1

only one)

29b. Signature and title

31. Date filed (Month. Day

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Kaman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaneux

32. Registrar's Signature

Fred Bothers

13.

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Back

29c. License number

29d. Date signed (Month, Day, Year)

21119

Westminsty

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Dep	partment of Health and M ertificate of Death	ental Hygiene Reg. No.	
	Physiciar		Registrar  Decedent's Name (First, Middle, Last) Efrain Rivera		2. Date of Death <b>Mary</b> 28,024	010 Year 3. Time of Death 12:57a <sub>M</sub>
	Medica Examine		a. Facility Name (if not institution, give street and number) 3507 Perry Street	4b. City, Town, or Location of Death Mt. Ranier	4 <u>P</u>	County of Death TINCE George's
*	Funeral Director		5. Social Security Number 1. Social Securit	Months Days Hours Min.	8. Date of Birth 3M/r00-124/, 109/3	g. Birthplace (State or Foreign Puerto Rico
			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation Ranier		10d. Inside City Limits 1 ☐ Yes 2 🎽 No
	tn tne Mar 3a or 28a- t be notifie	Funeral Director	10e. Street and Number 3507 Perry Street	10f. Zip Code 20712	10g. Citi	izen of What Country? SA
36	ould be filed within 72 hours after death with the Maryland and Mental Hygiene.  Id Mental Hygiene.  In Hygiene.  In Medical Examiner must be notified at matic event, the Medical Examiner must be notified at	<u>\$</u>	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces 1  Yes 2 No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Puerto 1 ☑ Yes 2 ☐ No Specify:	Rican, etc.) Rican	14. Race - American Indian, Black, Whith fite Specify:
Baltimore, Maryland 21215-0036	hin 72 hours ne. than "natura ie Medical E	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation ve kind of work done during most of work DONG (section)	ing	estaurant
and 21	oe filed with antal Hygier ked other t c event, th		17. Father's Name (First, Middle, Last) Narciso Rivera	Petra	ne (First, Middle, Maiden a Rivera	
Mary	12 should be file alth and Mental I 127 is marked o ir traumatic eve		Massici ni volu,	ailing Address (Street and Number or Run 12 Napier Street	1 20 1	Spring, Md 20906  coation - City or Town, State
more,	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic e once.		1 Burial 2 Cremation 3 Removal from State Cate		2/2010 Si	ilver Spring,Md
Balti	permit. Departn Importa any inju		21. Signature Willeral Bervice Ligense  23a. Part 1. Enter the disease, or complications that caused the death. Do not			SERVICE, P.A. r Spring, Md20910
B	Physician/Medical Medical Examiner and penulary femals is possible to the control of the control		Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arre	nary artery dis		Onset and Death
Box 68760	or Attending Physician: The law requires that the death certificate by after death.  Director: After this certificate has been signed by the attending physis in by the funeral director, page 2 should be detached for use as the b	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	is that the igned by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in Diabetes Mellitus	the underlying cause given in Part I.		ouse contribute to the cause of death? 2 🎦 No — 3 □ Probably —4 □ Unknown
Division of Vital Records,	≥ 8S ≤	npleted	Chronic lymphocytic leukemia	a 	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 ☐ Yes 2 ☐ No
l Re	n: The ficate I	S	25. Was case referred to medical	26. Place of Death (Ch	eck only one)	
/ita	ysicia s certi directo	To Be	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Out		Home 5 Residence	6 Other (Specify)
on of \	nding Phy ath. r: After this	Certificate: T	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28b. Ti (Month, Day, Year)	work?  M 1 Yes 2 No		and Number or Rural Route Number,
Division	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page				City or Town, Sta	are)
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowle	edge, death occurred at the time, date and	place, and due to the caus	se(s) and manner as stated.  Date signed (Month, Day, Year)
	or cor		29b. Signature and title of certifier	DC8053		ine 1,2010
				ameron Street	Silver Spi	cing,Md 20910
	S Regis	tate trar	31. Date filed (Month, Day, Year)  JUN 02 2010  32 Registrar's Signature	parle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ Anna Louana René 11:55 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Casey House-Montgomery Hospice Montgomery Derwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number (Month, Day **Funeral** Min. Days Hours 75 1 M 2 5 F 1934 Louisiana 434-46-1770 Yrs June Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" 10a. State 10b. County Director 1 Tes 2 X No Gaithersburg Marvland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number .rs 23a o. «r must b United States 20879 18403 Guildberry Court, Apt 204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black White etc. چ و 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify If Yes Give Creole 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) National Institutes College (1-4 or 5+) Elementary/Seconday (0-12) of Health Staff Assistant 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Vina Derousseau Gabriel Guillory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18403 Guildberry Ct., Apt 204, Gaithersburg, MD Daughter Nona Rene Mena 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition metropolitan 1 Burial 2 Cremation 3 Removal from State 30. 4 Donation 5 Other (Specify) Alexandria, Virginia 2010 Crematory 22. Name and Address of Facility DeVol Funeral Home, 21. Signa re of Funeral Service La M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 rter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the artifalure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 shock Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Day in the past 12 months? Other (specify) Pregnant at time of death а Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diane Ruckert, CRNP, 6001 Muncaster Mill Road, Derwood, MD 20855 31. Date filed (Month, Day, Year) State

Registrar

JUN 02

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May Month Herman P. Reid 2<sup>Day</sup> 2010 Physician/ 5:13 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Memorial Hospital Cheverly 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 19<u>23</u> Oct. 28 Days Hours North Carolina 86 Director 239-22-2000 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director 1 □XYes 2 □ No Capitol Heights Prince Georges MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20743 6814 Wynnleigh Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Evel III. Armed Forces?

1 X Yes 2 No
If Yes, Give 1946—
Year or Dates 1947 Black, White, etc. 9 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: "natural". Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mable Fox Hazel P. Reid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6814 Wynnleigh Road, Capitol Heights, MD 20743 Annie Ruth Reid - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 5/29/10 Harmony Memorial 22. Name and Address of Facility
McGuire Funeral Service, Inc.
7400 Georgia Ave., NW, Washington, D.C. 20012 Signature of Funeral Service Licensee vanna 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Acute Myocardial Infraction disease or condition resulting in death) Medical Cardiovascular Disease Examine Atherosclerotic Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown 2nd Stage Renal Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 ANo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 □**x**No 1 Tes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 5 Pending Natural 2 🗌 No 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D36757

State Registrar 30. Name and ag

31. Date filed (Mg

O. Jamieson, M.D., 106 Irving St., NW, Washington, D.C. 20010

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Ma	aryland?	•			Mental Hy	giene		0.5	1 1-
			Registrar  1. Decedent's Name (First, Middle,	l ast)	-	Certifica	ite of i	Death	2. Date of Dea	Reg. No.		3. Time o	of Death
4	Physici		Jean	Rose	R	owley			Month	Day	Year	10.3	_
To go	/Medio		4a. Facility Name (If not institution,				y, Town, o	Location of Death	)	4c. County of	of Death	<u> </u>	
			Golden Living					erland			gany		
247	Funeral Director		218-40-3139	3. Sex 1  M 2  F X  7. Age	e (In yrs. last) 68	birthday) If Und Yrs. Months	er 1 Year B Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Sep. 1	h y, Year)  4, 1941	9. Birthpl Count	ace (State try)	or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location				<u> </u>	10	0d. Inside C	City Limits
	Maryl -f sho ied a	tor	MD Alle	egany		Frostbu	rg					1 □ Yes	s 2□No
	r 28a	Director	10e. Street and Number		L	10f. Z	ip Code			10g. Citizen of W	hat Count	try?	
	th wit 23a o 1st be		111 Jones Col	urt				21532			JSA		
9	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	If Yes, Give		13. Was Dec If Yes, sp 1 ☐ Yes		ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- America k, White, e	etc.	
2-0036	hours tural"	ed by	3 Widowed 4 Divorced  15. Decedent's	Year or Dates:	16	 6a. Decedent's Us	ual Occur	ation		16b. Kind of Bus	W	hite	
Ċ	in 72 n "na nedic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5		(Give kind of v life. DO NOT	vork done i use retired	during most of wor 1)	king	TOD. KING OF BU.	111633/11Iu	uatry	
717	d with giene er tha	Completed	12	College (1-4or 5	·+)	Homema	aker			Own h	ome		
and	d tal	Be	17. Father's Name (First, Middle, La	ast)						Maiden Surname	<del>)</del>		
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Mary	d 2 Trains		19a. Informant's Name/Relationshi		sband <sup>1</sup>	9b. Mailing Addre		and Number or Ru Court		er, City or Town, S Stburg		<sup>Соде)</sup> ЛD 21	1532
<u>a</u>	s 1 and of Health item 27 other to		20a. Method of Disposition		20b. Place	of Disposition (N	ame of	- :	Date	20c. Location - (			
Baitimore,	Page ent c nt; if ry or		1 ☐ Burial 2 ☐ Xemation 3 4 ☐ Donation 5 ☐ Other (Spe			pelli Funera pelli Funera			6/4/2010	Cres	aptov	vn	MD
Rall	permit. Departm Importar any Inju		21. Signature of Juneral Sarvice 1	teneee		22, Name	and Addre Scarp 108 V	ss of Eacility elli Funeral I irginia Avent	lome, PA le: Cumber	land, MD 21	502		
	100		23a. Part J. Enter the disease, or/o shock, or heart failure. List of	omplications that caused	the death. D	o not enter the m	ode of dyin	ng, such as cardiad	or respiratory ar	rest,		Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition	- Glic	oblas	Forma 1	rul	titorn	al		13	Onset and	beath
~	/Medical Examiner		resulting in death)	Due to (or as a	a consequenc	ce of):							
		-	Sequentially list conditions,	b. Due to (or as a	a consequenc	se off:					- 1		
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i			,							
o,	an and rial-tra		that initiated events resulting in death) Last	Due to (or as a	a consequenc	ce of):							
58/50,	ificate be executed g physician and as the burial-transit	edical	•	d									
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Š Q	w requires that the death certifichers is the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal dea			1		23d. Date Mor	e of delive nth	ry Day	Year
j.	the d by the ached	nysid	1 ☐ Yes 2 ∰ No 9 ☐ Unknown	9☐ Unknown	ime or dodar	o d o i i o i	opcony/						
Ţ	requires that the een signed by the rould be detache	by Pi	Part II. Other significant condition	s contributing to death bu	ut not resulting	g in the underlying	cause giv	en in Part I.	23e. Did to	obacco use contri	bute to th	e cause of	death?
cords,	en sig								1 🗆 1	Yes 2□No	3 ☐ Prob	ably 4 🗖	Unknown
<u>က</u>	law reas be	Completed							24a. Was		Vere autor	psy findings	available cause of
	: The l	Con								rmed 6 d	eath? □Yes	2□ No	
VII	Physician: The law r this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea					
Ö	Attending Physician: r death. ector: After this certific. by the funeral director,	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	nt 2 ☐ ER/0 rv 28b	Outpatient 3 🗆 🛭	JOA	4 Nursing H		dence 6 Othe		<i>"</i>	
SION	nding th. : Afte s fune	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Day	Year)	Injury M	28c. Injur Wor 1 □	k? Yes 2∐No	Edd. Doddillo i	,on injury coolain	,,,		
	Atter	ifica	3 ☐ Suicide 6 ☐ Could no determin		iry - At home,	farm, street, facto	ory, office			Street and Number	er or Rura	l Route Nui	mber,
5	tal or rs afte al Dir ed in	Certification:	4 Ditionioide	building, etc	s. (Specify)				City or Tov	vn, State)			
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  4 CertifyIng 2 Medical E	Physician: To the best of caminer: On the basis of and manner sta	examination	dge, death occurre and/or investigation	ed at the tir	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause	(s)
	To the within to the complete	Me	29b. Signature and title of certifier	70 .		2	9c. Licens			29d. Date signed	(Month, I	Day, Year)	
			<b>)</b>	Jahr for	~3		100	33280		June	4, 2	2010	)
			30. Name and address of person w	no completed cause of de	eath (Item 23a	a) (Type, Print)		0		220	0		
		to	31. Date filed (Month, Day, Year)	O O Begistiv	25 KE ar's Signature	NJ HV	NUE	CUM	* KUHN	10, mo	215	X02	
	Sta Registr		NOC	0 20 0		for falls			•				

DHMH 17 Rev 1/2001

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 27, 2010 6:30 PM Norman Richard Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Lutheran Village Hlth. Care 9. Birthplace (State or Foreign PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 28, Yea 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **1** 2 □ F 81 163-22-7523 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Frederick Frederick MD 10g. Citizen of What Country? 10e Street and Number 11301 Liberty 21701° permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22000 If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Woodshop Teacher Montgomery Co. Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Niora Victor Howard Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6250 Woodwinds Ct., Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type. Print) Charles Smith - Son 20b. Place of Disposition (Name of Carrolly Correction (Name of Carrolly Correction (Name of Carrolly) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State 5/28/2010 Hampstead, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Each Funeral Home & Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** Congod /Medical Due to (or as a contequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ceuse of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 | Pending To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3∏ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number scensulipa, MD 05-28-2010

- was

State 31. Date fil Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANS URIYA 349 Mal Wolf

31. Date filed (Month, Day, Year)

JUN 01 2010

A Begistrar's Signature

DHMH 17 Rev 1/2001

westminster.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bish 20/0 9:10 A yalle 21 ONON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (ofinitely Wesminster ( DVV If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 ★ M 2 □ F 92 Months Days Hours Min. Year) Director 213-01-9976 Mar. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Me Iteal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 U.S.A. 323 Stoner Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces r 1XX es 2 No 1945 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Automobile Service Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Manager Stations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Robert Stephan Sarah Bish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Manual Print (Type, Print) 323 Stoner Ave., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Kriders Cemetery 6/01/2010 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Home & 21. Signature of Funeral, Service Licensee Chapel, P.A. Valley! 412 Washington Rd. Westminster. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HOUS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical Box 68760 attending pl IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv perform certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendir within 24 hours after death, To the Funeral Director: Af completed filled in by the fu death, 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month,

MIMO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 A M Wanda L. Somerville May 8:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 103 A Bloomsbury Square Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 ☐ M 2X F Hours Aug 6 1955 Maryland Director 214-66-4541 54 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Yes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 A Bloomsbury Square 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Completed Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Seconday (0-12) College (1-4 or 5+) 11th Maintenance Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ည John Spencer Sr. Elizabeth Brown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Wright(Son) Suitland, Md. 20746 3606 Wood Creek Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6-3-10 4 Donation 5 Other (Specify) Maryland Veteran ! Crownsville, Md. A Manne Bransen Feelin Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sign I be Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is a stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) a armi blem, DID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestagte Road # 300, Amapolis, MD 21401

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $2^{Day}$ May 2010 Howard Irving Schlosser 04:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1608 Arundel Road Edgewater If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 6. Sex 1. M 2 □ F 8. Date of Birth 07/20/1929 Washington, D.C. Director 577-32-7590 80 Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Marvland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must be Funeral 21037 United States 1608 Arundel Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Tile Setter (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Watson Howard I. Schlosser, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Sharon Rogers/Granddaughter 207 Cadle Avenue, Edgewater, Maryland 21037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 6/1/10 21. Signa Apple Price Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician alwe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner trolle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has to page 2 s To the Hospital or Attending Physician: The law autopsy perform death? certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t Natural 5 Pending work? decth. 2 🗆 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Underlined Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Griffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) May 158 1**6**6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Marcalus, 3168 Braverton Road, Suite 250, Edgewater, Maryland 21037 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

JUN 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Edward Lee Smith, Sr. 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner iSPU pice a 10 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex. 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday, **Funeral** Days June 20, Hours Min. Year 1931 78 Mary land 577-40-8544 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Somerset Westover Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA Funeral 21871 8787 Lisa Lane is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give 1948-5
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Yes 2 No Specify: Specify: White 1948-51 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter/Builder Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Lula D. King Francis W. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 West 27th Street, Baltimore, MD 21218 Sharon L. Smith/Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition June 5 cemetery, crematory or other place)
Gate of Heaven Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Eacht ins Funeral Home Inc. rancis J. Collins Funeral Home Inc. on University Blyd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Francis J. Collins Funer 500 University Blvd. W., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1) BMBN TIA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 🗌 Probably 4 🗌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an autopsy 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be examiner? Other: HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of eath Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

6 Human

31. Date filed (Month, Day, Year)
WIN 0 4 2010

WANS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2010 7:50am Donald L. Sherling Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) June 03 1 🛛 M 2 🗆 F Months Hours Min Washinaton. **Director** 579-48-1386 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 20906 U.S.A. 11818 Mentone Road hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 🔀 Yes 2 🗆 No 1953-Black, White, etc. 1 Never Married 2 X Married ρ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify Completed 3 Widowed 4 Divorced 1962 White. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rena Friedenbera Harry Sherling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11818 Mentone Road, Silver Spring, Maryland 20906 Ruth M. Sherling - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify) Judean Memorial Grdns:06/04/2010 | Olney, Maryland 21. Sig ature of Fun and Se vice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railore. List only one cause on each line. Approximate Interval Between Onset and Death 2 UCUS Immediate Cause (Final Priysician/ Colorectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last ttending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 🗌 No the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physiciam: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 🗶 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ro D54378 June 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl Aylesworth. MD. 2730 University Blvd., West. #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature State 2010 **JUN 04** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Saltzman Barbara May 31, 2010 10:24 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Min. 04/27/71932 New York Director 112-24-7326 Usual Residence of Decedent or 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Silver Spring Montgomery 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 15101 Interlachen Drive #917 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Celia "Unknown" Robert Bless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eli Saltzman - Husband 15101 Interlachen Drive #917 Silver Spring MD 20906 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gargenetery, crematory or other place)
Gargen of Kemembrance
Memorial Park 4 Donation 5 Other (Specify) 06/03/2010 Clarksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Eachty
Danzansky-Goldberg Memorial Chapels Inc
1170 Rockville Pike Rockville MD 20852 M01163 23a. First Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Severe Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pnuemonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 🔀 No 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X N 1 🗌 Yes s after death.

I Director: After this certificated in by the funeral director, p Be Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the P within 2 To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67386 May 31, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia John MD 9101 Medical Center Drive Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 4 2010 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Sch ieve 3:08 PM ina Medical Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Inversity of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year Director 234-92-1554 1959 Feb West Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 24620 Lunsford Court 20872 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natu
aumatic event, the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12College (1-4 or 5+) homemaker own home Be Page 1 and 2 should be filed of ment of Health and Mental Hygant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Billy Joe Miller Bernice Audrey White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 24620 Lunsford Court, Damascus, Maryland permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th John Schieve, husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 6/1/2010 Alexandria, Virginia 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee 20872 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Mocholic Circhosis Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): led by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 5 Pending 2 No \_\_ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PEMBROLE MD 0#19685 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St., Bartimore, MD 21201 Pembroke homas MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** R. Southard Ronald 2:52 PM 2010 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Federalsburg 3610 Houston Branch Road Caroline 8. Date of Birth (Month, Day, Year) Feb. 22, 1939 9. Birthplace (State or Foreign Country)
Delaware 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min 215-36-0377 71 Director Usual Residence of Decedent is filed within 72 hours after death with the Maryland of Hygiene.

other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Exandrer must be notified at Director 1 ☐ Yes 2 🕱 No MDCaroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3610 Houston Branch Road 21632 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1∑1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor E.I. DuPont 12 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked oth any Injury or other traumatic even 1 and 2 should be 1 Health and Mental Walter Southard Ruby Towers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2163219a. Informant's Name/Relationship (Type. Print) 3610 Houston Branch Rd. Federalsburg, Patricia Southard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cem. 6/2/2010 Federalsburg, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Politice CFSP Framptom Funeral Home, Federalsburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nneg? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

State Registrar

29b. Signature and title of certifier

-A KSHMI 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAIDYANATHAN

32. Registrar's Signature

DHMH 17 Rev 1/2001

51 PD

MD

29c. License number

219 S. WASHINGTON ST.

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** May Frances Louise Strasser 0820 20 3010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Eastor Under 1 Year | If Uni labot Hospital at Easter remona If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number **Funeral** 1 M 2 → F Months Days Hours Min. 78 Director 220-28-1971 14, 1932 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once. 1 ☐ Yes 2 XNo Director Maryland Caroline Goldsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21636 14461 Poplar Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Accountant Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Fleetwood Alday Hanley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward F. Strasser/spouse 14461 Poplar Street, Goldsboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 29, 2010 Hillsboro, Maryland Greenmount Cemetery 21. Signature of Fureral Service Licensee <sup>22</sup> Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 21639 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3 reast Conce months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burlal-trans and Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ۴ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Monte

1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) May 26, 2010

St. EASTON, NS 2/60/

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amended item 8/6-3-10/wchd/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200 Gary Sylvester Smith Sr. 10:52PM Medical . Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dalisbury Dice at the Vicomics If Under 1 Year If Under 24 Hrs At Date & Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Mignth, Day, 1 X M 2 □ F Months Days Hours Mary Tand 52 Director 219-62-9026 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 306 Maple Avenue 21811 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 ☐ Married Completed by and 21215-0036 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Wallace Purnell Carrie Mae Smith Baltimore, Maty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Maple Avenue - Berlin, MD 21811 Wallace Purnell / Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul UMC Cemetery 06/05/2010 Berlin, MD 21. Sig lature of Funeral Service Licensee 22. Name and Address of Facility Salisbury, MD Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC ANCREATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 2 000 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: Certificate: To HOSPILA 1 Inpatient 2 I ER/Outpatient 3 I DOA Other (Specify) 4 Nursing Home 5 Residence within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DO05 8410

State

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SACI BUNG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

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31. Date filed (Month

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egistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	for State Registrar	Ctate of Maryla	-	rtificate of		, ,	Reg. No.2 0   (	18927			
	Physici	an	Decedent's Name (First, Middle, La     Aruella Ell	st) len Shockley	7			2. Date of Dea Month	Day Yea	3. Time of Death			
40.13	/Medi Examir		4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Death	May 3	4c. County of De				
	Funeral Director		Social Security Number 6. S	Sex 7. Age (In yrs	s. last birthday) Yrs.	irthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth Months Days Hours Min (Month, Day Year)  Country)							
/land	MO!		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits			
ле Мап	8a-f sh pliffed	Director	Maryland Wicom	ico	Salis					1 ☐ Yes 2 🖾 No			
h with ti	23a or 2 st ben	al Dir	10e. Street and Number 30465 Zion Road			10f. Zip Code 2180	4		10g. Citizen of What ( uSA	Country?			
laryland 21215-0036  2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evan. Art. and the rollified at		by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: <b>b</b>				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft	giene. r than "natur the Medical	Completed	15. Decedent's Ec (Specify only highest gra	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired <b>nestic</b>	eation during most of work d)	ing	16b. Kind of Busines	•			
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, Mar) and 2 sho	of Health and Meritem 27 Is marker other traumatic		19a. Informant's Name/Relationship / Denise Marshall/r	Type. Print) 11ece					er, City or Town, State				
timore	Department of He Important: If iten any Injury or oth once.		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)	Removal from State Sp	fTMgh11 Gardens	sition (Name of Tator Memor place)	6 5	2010	20c. Location - City of Hebron, M				
Bal permit	Depar Impor any In		21. Signaturi of Funeral Service Idean	7 an_		2. Name and Addre tewart Fu	,	ne,821 W	est Rd.,Sa	alis.MD21801			
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petr	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conser	quence of).								
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다 다	To th comp	Me	29b. Signature and title of certifier	}	_	29c. Licens	number 5036	2	6 (2 (10	nth, Day, Year)			
	ju		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, I			31-10		I VE SAC.			
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		For State Registrar		State o	f Maryla		partment of H		Mental Hy	giene Reg. No.	010	8928
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the Funeral Director: After this certification in by the funeral director, completely filled in by the funeral director.	edical	(Check only 2 Medione)	al Exa	<b>miner:</b> On the b	asis of exami ner stated.	nation and/o	or investigation, in my o	pinion, death occ	curred at the time	, date and	place, and du	e to the cause(s)
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Funeral Director		5. Social Security Nur 213 34 (		ПМОПЕ	e (In yrs. I ' <b>3</b>	last birthda Yrs.	Months Days		(Month, D	ay, Year)	Co	hplace (State or Foreign untry)
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and z	Be	17. Father's Name (F						18. Mother's Nar			ŕ	
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of He		20a. Method of Dispo	osition	_	20b. P	lace of Dis	position (Name of rematory or other pla		Date	20c. Lo	cation - City or	Town, State
altimor rmit. Pages partment of portant: If it y injury or o			Other (Specify	Removal from State  ')	St.		er's Cer		7-2010	Wald	dorf,	Md
Day permit Depar Impor any In		21. Signature of Fund	eral Service Licens	see	DALL	-						RAL HOME
_ 1111 4		23a. Part 1. Enter the	disease or com	plications that caused	the death	Do not a					aldori	, MD20601 Approximate
Physician		shock, or heart Immediate Cause (F	failure. List only o inal	one cause on each li	ne.		To X	2 \ P	o or roopilatory	u-1700t,		Interval Between Onset and Death
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death certificate e attending physid for use as the b	ian/	23b. Was decedent p in the past 12 m	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	l death	3  Ectopic pregnan	су		2	23d. Date of de Month	livery Day Year
the d	Physician/Medica	1 □Yes 2 □ 9 □ Unknown	No	9 Unknown	it time or o		3 □ Other (specify)					
S, T	by P	Part II. Other signific	ant conditions co	ontributing to death b	out not resu	ulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco u	ise contribute t	o the cause of death?
ecords, P.O. law requires that the as been signed by th 2 should be detache									1 🗆	Yes 2[	□No 3□P	robably 4 TUnknown
VITAI MECOTOS, Iclan: The law requires t certificate has been signe ector, page 2 should be c	Completed								24a. Was	opsy	prior to	utopsy findings available completion of cause of
n: Th lificate or, pag		25. Was case referre	d to medical						1 □ Yes	ormed? 2 No	death?	2 🗆 No
ysicia ysicia is cert	To Be	examiner?		Hospital:	ent 2 🗆	FB/Outna	tient 3 DOA Ot	26. Place of Dea	ath <i>(Check only</i> Home 5 ☑ Res		6 □Other (Sp	ncify)
on or vital recting Physician: The law h. After this certificate has funeral director, page 2 s		27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da		28b. Time Injur	of 28c, Inju		28d. Describe			, and the second
VISION  Attending er death. rector: Afte	catic	2 Accident	investigation				M 1 [	]Yes 2□No				
after of Direct of Jin by	Certification:	4 ☐ Homicide	determined	building, el	ury - At ho c. <i>(Specif</i>	me, farm,	street, factory, office		28f. Location City or To	(Street an Swn, State	d Number or A )	ural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier 1, (Check only 2 one)	CertifyIng Phy	yslcian: To the best niner: On the basis of and manner st	of examina	wledge, de	eath occurred at the r investigation, in my	time, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s	) and manner a d place, and du	s stated. e to the cause(s)
To the within To the comple	Med	29b. Signature and tit	tle of certifier	and marrier st	ateu.		29c. Licer	se number		29d. Dat	te signed <i>(Mon</i>	th, Day, Year)
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DHMH 17 Rev 1/3	-			Marian		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 31° Lillian Smith 2010 May 3:40a M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🏻 F Months Hours 12/03/1918 Director 086-10-7560 91 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Rockville 1 🗌 Yes 2 🗓 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1801 East Jefferson Street, Apt. #427 20852 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 □·Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Perewiskin Morris Donishefsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 E. Jefferson Street, Apt. 427, Rockville, MD20852 Robert Smith - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Ft.\Lincoln Crematory 06/05/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mu #1070 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year 5 Other (specify) Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 1 Yes 2 X No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? C. Diff. Colitis 24a Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 sl performed? Yes 2 X No Encephalopathy 1 Yes 2 No 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗓 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, LILLIAN determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred at the time date and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) June 1, 2010 D0060117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Park, MD, 8600 Old Georgetown Road, Bethesda, Maryland JUN 02 2010 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $2^{\frac{4}{0}}$ 5:27 P M Ann Marie Scalley May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth **Funeral** (Month, Day, Year) Aug. 11, 1923 Days Hours Min. 86 Yrs Director 208-16-6584 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No D.C. Washington, D.C. none 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral filed within 72 hours after death with 4201 Butterworth Place, N.W. 20016 TISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 🗓 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker and Mental Hygier is marked other t 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Thomas O'Malley traumatic Ethel McIntyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 E.Deer Park Drive, Gaithersburg, Md. 20877 Mary Ellen Scalley/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, Maryland uner e ice icens 21. Signatur MO1315 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Pulmonary Embolism disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine Dualto for selection excuence on The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Day Pregnant at time of death 2 X No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Tes 2 No ☐ Yes 2 🔀 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔯 No Other: မ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pendina injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie Signatur 29d. Date signed (Month, Day, Year) 0068405 28/2010 verenal luto

Registrar
DHMH 17 Rev 7/2009

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Registrar's Signature

Jesus David Guevara-Nieto, MD, 8600 Old Georgetown Rd., Bethesda, Md. 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

IIIN 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Fidelina 2. Date of Death 3. Time of Death Saavedra Physician/ May 28, 2010 Year 1:00p M Medical 4a. Facility Name (if not institution, give street and number)
Holy Cross Hospital **Examiner** 4b. City, Town or Location of Death, Silver Spring 4c. County of Death Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **J (YPP)**告 De**2 (P**er) **1 9 1 7 Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Nirwaragua 1 □ M 2 🔀 F Months 212-96-9880 Days Hours Min. **Director** 28a-f shov 10b. Count City Town or Location
Silver Spring 10d. Inside City Limits **Funeral Director** Montgomery 1 🗆 Yes 2 🕇 No 10f. Zip Code 20906 10e. Street and Number 13407 Hathaway Drive 10g. Citizen of What Country? Nicaragua and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Nicaraguan Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work going life. DO NOT use retired HOMEMaker (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rafaela Saavedra 27 is marked or traumatic ever ၉ Sebastian Lopez 9a Informant's Name/Relationship (Type, Print)
Francisco Jose Saavedra/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 13407 Hathaway Drive Silver Spring,Md20906 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemeter, crematory of the place ipal 6/9/2010 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Leon, Nicaragua 4 Donation 5 Other (Specify) 21. Signature PANITE TO PADES REMALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) weeks Death Physician/ Pneumonia Medical Due to (or as a consequence of): Examiner End stage Dementia years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Acute renal failure week use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for i in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by benign essential hypertension Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) 24a Was an autopsy Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural the Hospital or Attending 5 Pending injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 1 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and a dress of person who are related as Middle at the 1500 Type of the st Glen Road Silver Spring, Md 20910

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month KENNETH DWIGHT STEVENS 300 20T0 7:51 р Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montogmery Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XM 2 | F Hours Sep 7, 578-78-6843 Director 50 DC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo! DC Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3332 Tenth Pl. SE 20032 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Rogers Park Public 4 yrs Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David E. Stevens Gertrude A. Jovner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3332 Tenth P1. SE Washington, DC 20032 Gertrude A. Stevens - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 6-4-2010 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Marshallos Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ HEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EFFUSION GRICARDIAL Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury that initiated events )TA(-2 sician and burial-transit 15GASE HROULL Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician # Physician/Medical TNPECTION Division of Vital Records, P.O. Box 68760 the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the a Yes 2 No Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENDOCHROITIS BACTERIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔂 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA \_4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Matural Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 004495 2010 May leath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 20912 1600

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CARROLL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May THOMPSON 3:04 A M ALVIN WAYNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Yea March 14, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Year) Director 216-38-6180 73 Usual Residence of Decedent or 28a-f show 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 No Maryland Frederick Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2192 Sugarloaf Parkview Lane 20871 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Helper and Delivery Person Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Laury Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic William Earl Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Thompson, wife 2192 Sugarloaf Parkview Lane, Clarksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 6/3/10 Frederick, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 yan 23a. Parv 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MONTHS disease or condition Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 🗌 Yes 2 🗆 No 2 X N 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Tes 2 No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature DOOL 1213 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SUCTE # 135 FREDEUCE ND 21702

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Cerun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Towers Thomas Otis 320 Medical )une 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria 0/5 aston Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yolovember 3, Funeral 6. Sex 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Min. Hours Mary Land 62 218-48-6251 Director Yrs 1947 Vovember Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Caroline Queen Anne Maryland 1 Yes 2 X No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral United States of America 21657 .3283 Cherry Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", Completed 3 Widowed 4 Divorced <sup>Specify:</sup> Caucasian Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Starkey Louise Samue1 Towers Rav 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21657 19a. Informant's Name/Relationship (Type, Print) 13283 Cherry Lane, Queen Anne, Maryland Sherry Towers Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🔯 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place Greensboro, Maryland 6/7/2010 Greensboro Cemetery 4 Donation 5 Other (Specify) f Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 1004 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) cand Ventrice Medical Due to (or as a consequence of): Examiner structive Sequentially list conditions. ē cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) for 5 Other (specify) Month Day Year Pregnant at time of death the page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No Yes 2 No Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Hospita Other: 1 🗌 Yes 2 No ျှ 1 Lopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident 1 🗌 Yes Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination arrow investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 000 53110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 South Washington Street, Easton, Maryland 21601

DHMH 17 Rev 7/2009

State Registrar M.D

. Registrar's Sig

Dennis DeShields,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Year 1:50 PM Marie W. Taney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7600 Highview Pl. LaPlata Charles 8. Date of Birth (Month, Day, June 26, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Months Days Hours Min. Washington, DC Director 64 213 44 3830 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland LaPlata Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7600 Highview Pl. 20646 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Accounting Manager **Accounting** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Angelo Bello Carmella Longo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Taney (Husband) 7600 Highview Pl. LaPlata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 6/4/2010 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery : MO1555 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Ligensee 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 | Unknown þ s been signed b 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🔲 No 3 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred Hospital or Attending Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Deftifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

U 3 20

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:50 P. May 24, 2010 Marguerite Elizabeth Thring /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care Silver Spring 8. Date of Birth (Month, Day, Year) FEB. 17, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🗓 F 1940 Washington, DC Yrs. 578-54-1940 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehr... any injury or other traumatic event, the Medical Exceptions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 📉 No Directo Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20904 2501 Musgrove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Caucasian Specify þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Marguerite Bell Ronald Gill Thring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)Daughter-1304 Heights Drive, Santa Clara, UT 84765 DeAnn McFarland-Thorley, in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition May 28, 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a.
7 Park Avenue, Gaithersburg, MD 20877 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bruin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed reason sician and burlal-trans Due to (or as a consequence of): attending physician for use as the burla Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes P.O. the 9□ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate has funeral director, page 2: 2 DNo DOIZUNO Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Varsing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 1 No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 27. Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred After t (Month, Day Year) Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. o the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and hitle of certifier Rd #216 ROCKVILLE, MD, ZOSSZ. rson who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2010 Registrar

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		For State Registrar		State of M		/ Dep		of Hea	alth a	ind M	ental Hy	gien Reg. N	201	0	8938
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nine		4a. Facility Name (	If not institution, Cross	give street and number Hospital	)		4b. City, To	wn, or Lo Lver	cation of	Death ring	J	40	County of D		ery
al or		5. Social Security N 577-80-	1	6. Sex 7. A	ge (In yrs. last 68	birthday) Yrs.	If Under 1 Months		Under 2 Hours	4 Hrs. Min.	8. Date of Bird	th yy Year	941	Birthpl Grunt	ace (State or Foreign
	ctor	Usual Residence of 10a. State MD	10b. County	gomery	10c. City, To		Sprin	ıg						10	ld. Inside City Limits 1 □Yes Ž No
:	al Dire	2307 R	mber Ross Ro	oad			10f. Zip C	2091	0			10g. C	itizen of What USA	Count	ry?
	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		12. Was Decedent Armed Forces ed 1 yes 2 fif yes, Give Year or Dates:	2		Was Deceder If Yes, specify 1 ☐ Yes 2	7	anic Orig Mexican, Specify:	in? (Spec Puerto P	cify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:	hite, e	
	complete	(Speci		s Education t grade completed) College (1-4or	117	6a. Dece (Give life.	dent's Usual ( kind of work DO NOT use HOMEN	done durii retired)	ng most	of workin	g		Own Ho		ustry
	lo Be	17. Father's Name Herman						18			(First, Middle, Vivi		n Surname)		
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n al er	cal Examiner	shock, or hea Immediate Cause disease or condition resulting in death)  Sequentially list control in a cause. Enter Unde Cause (Disease or that initiated events resulting in death) in the control in the cause (Disease or that initiated events resulting in death) in the control in the cause (Disease or that initiated events resulting in death) in the control in the cause (Disease or the cause of the cause	(Final on a state of the state	Due to (or as Meta	e Streaconsequent	oke ce of): c br					respiratory a				Approximate Interval Between Onset and Death
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10 14 6	ed by FI	Part II. Other signif	ficant condition	ns contributing to death b	out not resulting	g in the u	nderlying caus	se given ii	n Part I.						e cause of death?
- Camo	naidilloo	-									24a. Was autop perfo 1 □ Yes		24b. Were prior deatl	ነ?	sy findings available apletion of cause of
7.00 oF .00		25. Was case reference examiner? 1 ☐ Yes 2 ☑ 27. Manner of Deat	No	28a. Date of Init	ent 2 ER/	b. Time o		Other:	4 🗆 Nur	sing Hom	(Check only one 5 ☐ Resided Bd. Describe I	dence		Specify	)
Cortification	CI III Callo	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investiga 6 Could no determin	ot be 28e. Place of Inj		Injury , farm, str	M	Work? 1 ☐ Yes	; 2□N	0		Street a	nd Number o	r Rural	Route Number,
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Registrar

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ROBER		CHARLES	TALER	TCO					May	28	2010	7:40 am		
4a Fecility Name (I			imber)				4b. City, To	wn, or L	ocation of Death	4c. Coun	ity of Death			
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5. Social Security N		6. Sex 1. 2XM 2 ☐ F	7. Age (In y	,		Inder 1 Yea oths Days		Min.	8. Date of Birth (Month, Dey,	Year)	9. Birthp	lace (State or Foreigntry)		
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10e. Street end Nur		Georges	Su	itlar		f. Zip Code			10	a Citizon o	f Whet Coun	tn/2		
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3 D Widowed		If Yes, Gi	ve		1□ Y	1 ☐ Yes 2 ☐ No Specify: Specify:								
	15. Decedent			160	Decedent's	Heuri Occi	nation		-	Ch Kind of	Wh: Business/Inc			
	fy only highes	t grede completed)		100.	(Give kind o	of work done  OT use retin	during mos d)	t of work	ing '	DD. KING OF	Dusiness/inc	Justry		
Elementary/Secon	ndary (0-12)	College (	1-4or 5+)		les		-/			orion	s Comp	ania.		
17. Father's Name (	First, Middle, I	Last)	-	l Da	TES_		18. Mothe	r's Name	e (First, Middle, M			Danies		
Francis	S. Tale	rico							Budd		/			
19a. Informant's Ne				19b	Mailing Add	trace (Strac			al Route Number,	City or Tow	n State Zie	Codo)		
		- Daugh	tor											
20a. Method of Disp		Daugiii			Disposition		pect A	ve.	Clearwa		FI. 33			
1 ☐ Burial 2 ☐	Cremation	3 Removal from		cemetery	r, crematory	or other pla	ice)	1	Date 2	oc. Location	1 City of 10	wii, State		
4 Donation			M	etrop	olita	n Cre	matory	. 6	5-3-2010	Alex	andria	yA.		
21. Signature of Eur	ieral Service L	icensee			22 Nam Mar	shall	ess of Facilit S Fun	eral	Home of	Marv	land			
Ullelo	LENO,	11/11/00	de				land		Suitlan					
23a. Part1. Enter th shock, or hear	e disease, ora failure. List	complications that only one ceuse on e	aused the de ach line.	ath. Do n	ot enter the	mode of dy	ng, such as	cardiac (	or respiratory arres	it,		Approximate Interval Between Onset and Death		
Immediate Cause (F disease or condition	inal	Lung	Cance	r							1			
resulting in deeth)		e			onsequence	of);								
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Sequentially list con	ditions.	Ь	Due to (or es e consequence of):											
f eny, leading to imi cause. Enter Under	nediate Vina													
Cause (Disease or in het initiated events		c	Due to	(or as e co	nsequence	of):								
esulting in death) L	181					,					i			
		d									i i			

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Peges 1 and 2 should be filed within 72 hours after deeth with the Marylend

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mantel Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at

Be Completed by Funeral Director

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75 / 7 N e 31. Dete filed (Month, Day, Year) JUN 0 3 2010

Examiner en end rial-transit

To the

l or Attending Physician: The law raquiras that tha daath certificate be aftar deeth.	<b>Director:</b> After this certificate has been signed by the attanding physicic is in by the funaral director, page 2 should be detached for use as the bu	
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Division of Vital Records, P.O. Box 68760,

Part II. Other significent conditions of Chronic Obstructi	23b. Did tobacco use co	ontribute to the cause of death 3 ☐ Probably 4 Ñ Unknow								
Anemia, Depressi	on			24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
25. Was case referred to medical			26 Place of D	eath (Check only one)	1 Yes 2 No					
examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	Othor	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)					
27. Menner of Deeth  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigetion		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	28f. Location (Street and Numb City or Town, State)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier  (Check only one)  1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier	of G	2	9c. License number	29d. Date signe	nd (Month, Day, Year)					

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? Ollie Rose Tompkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Month Year Medical Examiner TOMPKINS 1443 hrs ROSE OLLIE June 4, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12801 Berwick Circle Fort Washington Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Foreign ALABAMA **Funeral** Min Months Davs Hours Director DEC. 20 1941 424-58-8099 68 1 M 2 X F Country) Usual Residence of Decedent 'n 10c. City, Town or Location 10d. Inside City Limits 10b. County s 23a or 28a-f show e notified at once. show FT. WASHINGTON 1 X Yes 2 No PRINCE GEORGE'S Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 12801 BERWICK CIRCLE 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 Yes 3 Widowed 4 XDivorced If Yes, Give Year Yes 2 X No specify: Specify: BLACK ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical EDITOR PRIVATE 12TH 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be TILLIE SMITH ACIE JONES 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it: If item 27 is nother traumatic SCHANTEL TOMPKINS/DAUGHTER 6932 STORCH CIRCLE LANHAM, MARYLAND 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place) Removal from State 6/11/2010 RIVERDALE, MARYLAND Donation 5 Other Specify RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND s that caused Pe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only Between Onset and /Medical Atherosclerotic cardivoascular disease complicated by Death Immediate Cause (Final disease Examiner Due to (or as a consequence of): hyperthermia or condition resulting in death) Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence or). events resulting in death) Last and tran Physician/Medical X UNPENDED tending physician are use as the burial -AMENDED ,27,28a-f,per ME g905 7/13/10 TT The law requires that the death certificate be of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred
Found in a very warm Certification Natural 1 Yes 2 X No Director: In by the f Pending 24 hours a er death. 2 Accident Fd 6/4/10 Fd 2:30 pm environment Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12801 Berwick Circle t. Washington, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be To the Funeral I determined To the Hospital Washington, Homicide House 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 5, 2010 Isule Millerie 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

OCMF 2006

DHMH 17 Rev 1/2001

Margarita Korell MD.

31. Date filed (Month, Day Year)

32. Registrar'n Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2230 Lloyd James Taylor M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMICO SOLISHEU TENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country) Maryland 1 X M 2 🗆 F Months Days Min Director 213-36-7359 69 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Somerset Deal Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23354 Benton Road 21821 IISA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ✓ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1960–62 White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. none Waterman Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer B. Taylor Alphonza Parkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a Important: If item 27 any injury or other to once. <u>Jerry Taylor/Brother</u> <u>23354 Benton Road, Deal Island, MD 21821</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State St. Pauls U.M. Cem. 05/24/2010 Wenona, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Home Hinman Funeral Home M00295 11673 Somerset Princess Anne, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ drowning disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗆 No Other: ျ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural
Accident iniury 5 Pending Felloverbound bout UKW 2 No М 1 Yes Investigation ストン 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined MD oft deal Tangrer Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) HJOUG) 5/21/10 OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CAINI egistrar's Signatu State

Registrar DHMH 17 Rev 7/2009

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death
1235 Physician/ Pauline Teter 1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death WMHS-RMC Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Days Hours Month, Day, Apr 9. Director 213-24-6392 87 show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sh notified MD Allegany Cumberland 1 ☐xYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21502 1516 E.Oldtown Manor Apt. F USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Otis Miller Virginia (Hause) Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1516 E. Oldtown Manor Apt. F Cumberland MD MD 21502 Richard Teter son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1  $\overline{\mathbf{X}}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Sunset Memorial Park 6/12/201b MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service X 22. Name and Address of Facility Park PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Parv. Enter the fine se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ urd disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner orderlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 1 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 Accident
3 Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To t best f my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis f examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

924 SE

30. Name and address of perso who completed cause of death (Item 23a) (Type, Print)

VIKRAMADITYA POONAI M.D.

JUN 16

Date filed (Month, Day, Year)

June 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 11, 2010 Year ELIZABETH ANN TOMPKINS 8:35P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15085 SHADOW CREEK PL. WALDORF CHARLES If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗔 Hours 2/Mo2/5 Day 1/9/3 5 75 WASH., D.C. 339-30-1989 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director MD. CHARLES WALDORF 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f, Zip Code 9 10g. Citizen of What Country? Funeral 23a 11080 WEYMOUTH COURT 20603 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWHITE 3 Widowed 4 XDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) DEPT. OF NAVY Elementary/Seconday (0-12) College (1-4 or 5+) LOGISTICÍAN U.S.GOVT. 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GODFREY FRANCIS MUCKELBAUER LEOTA L. ESENMENGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLENN MAYHEW-SON 1385 REDWOOD CIRCLE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Cemetery, Cremation 5 ☐ Other (Specify)

METR OPOLITAN CREMATORY 6-14-10 22. Name and Address of Facility
RAYMOND FUNERAL SERVI
LA PLATA, MARYLAND 206 21. Signature of Ingeral Service Licenses M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bra ncer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician. The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Tether (Specify) 1 🗌 Yes 2 10 ၉ this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Af 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend # 18 tper of Mas and 7021/10 TT of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lidio May 29, 2010 Year Physician/ De Jesus Ventura 11:35a4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth May 2<sup>a7</sup>, 1937 Copin Salvador 7. Age (In yrs. last birthday) Social Security Number 218-59-6513 If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Director Usual Residence of Decedent 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Silver Spring Montgomery 1 Yes 2X No 10e. Street and Number 2666 Cory Terrace 10g. Citizen of What Country? 10f. Zip Code 20912 El Salvador 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental F Francisco Ventura Geronima De Jesus Quezada <u>Jeronima</u> 19a. Informant's Name/Relationship (Type, Prinsis—in—la Web. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11cia Esther Flores/
21 Burnt Woods Court Germantown.Md permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Burnt Woods Court Germantown, Md 20874 20c. Location - City or Town, State
LaUnion, El Salvador 20a. Method of Disposition 20b. Place of Disposition (Name of 6/9/2°010 1 → Burial 2 ☐ Cremation Removal from State Jardines Del Golfo 4 Donation 5 Other (Specify) PHNI TO PAD SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic lung cancer Pmysician/ mo. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 VIEWTHA LIDIO DEJESTA 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Dav signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ hypertension, end stage renal disease, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen plural effusion, severe systolic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? Yes 2 No dysfunction, coronary artery disease After this certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Katural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Sal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 □ only one) 29d. Date signed (Month, Day, Year) May 29, 2010 29b. Signature and title of certifier D53367 mom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shyamsundar Rajan M.D. 1500 Forest Glen Road Silver Spring, Md 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2010 back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death **Physician** /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Regional Mosputa aure If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 5, 1936 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Months Days Hours Min. 218-34-6788 74 Director Tennessee Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathh and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Prince George's Director Maryland Beltsville 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5014 Naples Avenue 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. □Yes 2 Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Ye ar or Dates er than "nature , the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ייים יאפונוזיי איים איים איים איים איים איים ז' 27 is marked other than "רי traumatic event" ייי traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Stone Straw Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Reynolds Eunice Hensley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5014 Naples Avenue Beltsville, Maryland 20705 Edgar W. Vigar, Jr. -husband or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 5/27/2010 Brentwood, Maryland 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications and a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespinstory Cardio **Physician** /Medical Due to (or as a consequence of) Examiner Sersis Sequentially list conditions Dud to (or as a consequence of): day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed director, page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐ Yes 2 No 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. n 24 hours after death.

le Funeral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69247 10 address of person who completed cause of death (Item 23a) (Type, Print) Dusen laurel, MD 20707

Registrar

State

2010

10-04341 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alonzo Argueta State of Maryland / Department of Health and Mental Hygiene 010 18946 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** Alonso Arqueta Ventura 1609 hrs June 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** 9. Birthplace (State or Months Days Hours Director 084-84-4921 47 1 M 2 F 10/1/1962 Country) El Salvador Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified as annex Maryland | Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3610 Brooklyn Ave. 21225 El Salvador Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Yes 3 Widowed 4 Divorced f Yes, Give Year 1 X Yes 2 No specifical Vadorian Specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Self Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Teodoro Arqueta Be Juana Ventura 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nahon Alexis Diaz (Son) 3610 Brooklyn Ave. Baltimore, MD. 21225 20a, Method of Disposition 20c. Location - City or Town, State timore, 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) Corinto Morasan Important: injury or oth Cementerio General 06/14/2010 permit. Page Department Donation Other Specify: 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licenses 9013 Annapolis Rd. Lanham, MD 20706 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death Myocarditis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed ted by the attending physician and detached for use as the burial - transi sician/Medical **X** UNPENDED AMENDED 23a,27 per me g906 8-5-10 vt Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 된 of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this DOA 1 🗸 Yes ဥ 27. Manner of Death After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division 5 Pending 1 Yes 2 No To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 32. Registrar Signat

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			1 _ State	State of M	laryland		ertment of l tificate of l		d Mental H	ygiene	- 010	0 1 4
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cer	uncate or i	Death	2. Date of I	Reg. No	0	10.7
	Physici Medi				16616	+Ms			Month 5	Da 3 1	y Year	3. Time of Death 5:55 (N
	Exami	ner	4a. Facility Name (if not institution, CARROLL HO	give street and number)	LENTI	EPZ.	4b. City, Town, a	r Location of De	ath STER, M	D 4c	CARR	th
	Funeral Director		220-42-6360	6. Sex 7. Ag 1 □ M 2 🔀 F	ge (In yrs. last 65	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		oay 1945	9. Bit Co	thplace (State or Foreign nuntry) MD
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Carr  10e. Street and Number	oll	10c. City, 1	Fink	ation Sburg 10f. Zip Code					10d. Inside City Limits 1 ☐ Yes 2 😿 N
	with t	eral	2416 Cedarhurs	+ Dr				136			tizen of What Co	ountry?
Maryland 21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent		lf	as Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pue		)-	JSA 14. Race - Ame Black, Whit Specify: Wh	
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yla	uld be I Ment narker	은	Lee Ellswort						Betty Wi	ckens	5	
Mar	2 shouth and the and the standard traum		19a. Informant's Name/Relationshi				Address (Street					/
ř.	f Heal item 2		20a. Method of Disposition		20b. Plac		Cedarhur	st Dr.	Reister		ocation - City or	
imo	Page nent o ant: If ury or		1 🔀Burial 2 □ Cremation : 4 □ Donation 5 □ Other (Sp		cem	etery, crema	atory or other place		5/2010	1	•	laryland
Baltimore,	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other th any injury or other traumatic event, the Once.		21. Signature of Funeral Service his	censee		22.	Name and Address  Washing	ss of FacilitPr:	itts Fun	eral	Home &	Chapel, PA
	Physician/ Medical		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	10 RE	onot enter	the mode of dyin	g, such as cardi	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death ろくん
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Conc		ce of):	PART.					48hrs.
	be executed sician and burial-transit	cal Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. BLOOD  Due to (or as a			OF AT	JEMI	A			4 days.
760	cate by physic the b			d								
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physi completed filled in by the funeral director, page 2 should be detached for use as the beautily the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant at 9  Unknown	2 ☐ Fetal de	eath 3 ∐ l	Ectopic pregnanc Other (specify)	у		-	23d. Date of del Month	ivery Day Year
», P.O	es that the signed by		Part II. Other significant condition RETROPER TO	s contributing to death be	ut not resultin	ng in the und	derlying cause giv	en in Part I.				the cause of death?
cords	law requi has been e 2 should	Completed by	GOUT, DA	1-2, OBE	SITY	, <sub>K</sub>	MANAIN	Ds	24a. Was	an	24b. Were aut	obably 4 Unknown  opsy findings available ompletion of cause of
I R	n; The ficate n, pag		25. Was case referred to medical	-					1 🗆 Yes	ormed?	death?	2 🗆 No
Vita	ysicial s certii directo	To Be	examiner?  1  Yes 2 No	Hospital:	ent 2 🗆 ER/	Outpotiont	Otho	ce of Death (Ch				
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Division of Vital Records, P.O.	r Attendii ter death. irector: Ai n by the fu	Certificate:	1	tion t be	ry - At home,			yes 2 □ No			Number or Run	al Route Number,
Ö	ospital c	ह्य -	29a. Certifier 1 Certifying P	hvsician: To the best of r	nv knowledo	e, death occ	cured at the time,	date and place,	City or Tou	nice(c) and	d manner as stat	ed.
	the H thin 24 the Fi		only one) 3 Certifying N	miner: On the basis of ex urse Practioner: To the b	amination and	d/or investiga	ation, in my opinion ath occurred at the	time, date and p	at the time date	and place	and due to the a	augustal and manage state
	WIL	ľ	29b. Signature and title of certifier	8 MD			Do O	6/55	8	29d. Date	signed (Month,	Day, Year)

State Registrar

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STONER AVE

WESTMINSTER, MOZI157

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLUNI ARIKH MD. 295

FALLIUNI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Edward Wilson Mary Mary 30<sup>Day</sup> 20°70 5:59 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Carroll County 4230 Crystal Court, Apt. Ham: stead 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 € M 2 □ F 219-44-9258 Months Days Hours Min. 63 Yrs Maryland Director Ĩ946 July Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits "natural", or items 23a or 28a-f s Maryland Carroll County Hampstead 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4230 Crystal Court, Apt. 2-B 21074 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction construction it. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Melvina Hoffman Harry Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5186 Manor Court Spring Grove, PA 17362 William E. Wilson, Jr. / son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of June 1 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licen Eline Funeral Home 22. Name and Address of Facility M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final U Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Of impuly that initiated events Physician/Medical Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has eral Director; After this certificate I filled in by the funeral director, page performed 2 🗆 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 盎 26. Place of Death (Check only one) examiner? 1 Yes Hospital: 2 🗌 No Other: 옏 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sign ture and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) un State Registrar

## For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician/ Mav George Wenn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis 915 Carrollton Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Juneth, Payl Year 1929 1 🛛 M 2 🗆 F Months Hours Min. 216-22-3335 80 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 915 Carrollton Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry United States Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Engineer Coastal Guard is marked other injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ George Wenn Charlotte Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marion Wenn(Wife) Annapolis, Md. 21401 Carrollton Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl 1 X Buriai 2 Cremation 3 Removal from State Annapolis, Md. Brewer Hill 6-2-10 4 Donation 5 Other (Specify) Windame a Rock of Facility Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 MO0483 D. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final ND STAGE LIVER Physician/ Medical resulting in death) Examiner RRHUSIS Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Records, 1 Yes peen 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10:35AM

Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

Maryland

2010

USA

Specify:

14. Race - American Indian,

Black

Approximate

Onset and Death

Black, White, etc

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

3 Probably 4 Unknown

Year

Month

29d. Date signed (Month,

Anne Arundel

NA

State Registrar only one

Signature and title of certifier

ame and address of person who completed cause of death (Item 23a) (Type, Print)

RANDALL IND 2629 RIVARD, SELL2 Chanapolis WD 21401

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20042752

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 May Irmgard Hildegard Wood /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospital Prince George's Laurel Regional Laure Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
October 23, 1933 6. Sex 7. Age (In yrs. last birthday) Social Security Number Funeral Min. 1 □ M 2**∑** F Months Days Hours 76 Germany Director 212-54-9198 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modical Erro, instrumatic motified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20707 USA 407 Domer Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Completed by White 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fritz Klein Karolina Rautz မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 Is any Injury or other trau Once. 2316 Cross Section Rd., Westminster, Maryland 21158 Siegfried Wood-SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt/Wash Crematory May 27, 2010 Laurel, Maryland 22. Name and Address of Facility
Fleck Funeral Home, INC.
7601 Sandy Spring Rd., Laurel, Maryland 20707 21. Signature of Fune 11 ervice Licensee MU1237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** /Medical Due to (or as a consequence of): ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician end for use as the buriel-transit Congestive Heart Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Obstructi Completed 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary 24a. Was an autopsy performed After this certificate Disease Artery 2 No Coronary 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, ours after death.

eral Director; After this certifica filled in by the funeral director, p within 24 hours a To the Funeral L Hospitai

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

Nega 31. Date filed (Month, **JUN 0 1** 2010

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali (50JI,

Year)

Laurel Regional

D 8669430

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

7300 Van Dusen Road MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 5 Dav Year Physician/ AM 2010 Michae Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner medical mor 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Sex Funeral Feb. 28, Year) D.C. 213-44-7368 64 Director Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County the Maryland Director 1 Yes 2 No Talbot Faston Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA Funeral P.O. Box 2740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ 1 X Yes permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir once. Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. 1966-72 Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Commercial Real College (1-4 or 5+) Elementary/Seconday (0-12) Estate 4 Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Heintz 2 Walter Windsor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 2740, Easton, MD 21601 Susette M. Windsor/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee reisod Address h Facility Funeral Home Inc. University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death g Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 X No filled in by the funeral director, page 2 1 🗌 Yes 2 😿 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. injury 1 🖬 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one 29d. Date signed (Month, Day, Year) 29c. License number UmD Medical 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 5. Greene St Baltimore 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

**Physician** /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

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Health em 27 i

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

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and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit of in by the funeral director, page 2 should be detached for use as the burial-transit filled in by Hospital of 24 hours at Euneral D

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year							
Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		use contribute to the cause of death?  ☑ No 3☐ Probably 4☐ Unknown				
			24a. Was an autopsy performed? 1 □ Yes 2⊠No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No					
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐	 ] ER/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)				
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how inju	ry occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	23b. Was decedent pregnant in the past 12 months?  1	23b. Was decedent pregnant in the past 12 months?  1	23b. Was decedent pregnant in the past 12 months?  1	23b. Was decedent pregnant in the past 12 months?  1	23b. Was decedent pregnant in the past 12 months?  1				

29c. License number

29d. Date signed (Month, Day, Year)

JUNE 3 2010

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title

32. Registrar's Signature 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2250 Sylvester Lee Watson, Sr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICS SALISBUR If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 🛛 M 2 🗆 F Months Hours Min oct. 14, 1930 Maryland 220-26-3376 79 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importants if tiem 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examinar must han matter a --10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral USA 21801 813 Oneida Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian 11. Marital Status Black, White, etc. Armed Force: 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Perdue Laborer 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Foreman William Watson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 813 Oneida Ave. - Salisbury, MD 21801 <u> Mable Odessa Watson / Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Snow Hill, MD 106/05/2010 4 Donation 5 Other (Specify) Mt. Wesley UMC Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Salisbury, MD Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician Aspiration disease or condition resulting in death) Medical Due to (or as a consequence of Examiner quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ASCVI) Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? nerform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 A No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number D57952 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 106 Milford ST. # 504B, Salisbury, MD21804 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Williams Lee :00 M Dorothy Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisburg If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 ื F 1170971929 Min. Maryland 213-24-1264 Director 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🏝 No Wicomico Hebron Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21830 USA 6706 Oak Ridge Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 XNo 1 Never Married 2 X Married should be filed within 72 hours after in and Mental Hygiene. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Register of Wills registar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Parker ೭ Hanson Wootten of Page 1 and 2 shours of Health and Mr. "12 fr." 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Welsh/daughter 616 Indian lane, Salisbury, MD 21801 Department of Hea Important: If item 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/30/2010 Baltimore, MD 4 🛮 Donation 5 🗆 Other (Specify) Maryland Anatomy Board ature of Funeral Service Licensee PHOTTOWAY PUNETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Domon Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CERRBROVASULAR Physician/ DAYS ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 
Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: To 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hungy 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State JUN 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ mai Waller 30 2306 M Anita Wachsmuth 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER SALISHIRU HICOMICO ROGIONAL 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. (Month, Day **Director** 214-28-8793 10-8-1932 Pennsylvania Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 1004 Beaglin Park Drive, Apt. 101 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Treasurer Plumbing permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wachsmuth Pauline Davis Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57069 19a. Informant's Name/Relationship (Type, Print) 417 E. Lewis Street, Vermillion, South Dakota Steven Waller - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Wicomico Memorial Pk. 6-3-2010 Salisbury, Maryland Sonature f Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one of Immediate Cause (Final disease or condition Ph sician/ tha Medical resulting in death) Examiner Sequentially list conditions, Examiner rany reading to infinishiate cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and vate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie License numbe မ 00066986

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

back Carrollst.

State of Maryland / Department of Health and Mental Hygiene

State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 2010 7:00 PM M 30, May Helen Miles Wells /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montgomery Wilson Health Care Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2**X** F 95 April 19,1915 Maryland 217-42-0906 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show s 23a or 28a-f show 1 XYes 2 ☐ No Funeral Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 United States 401 Russell Avenue, # 305 death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Exerters. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2K No Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home 12 Housewife 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ William Miles Mamie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15813 Ancient Oak Drive, Gaithersburg, MD. 20878 John Wells/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Mem. Park 6/5/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONC disease or condition resulting in death) 25/ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physloian page 2 should be detached for use as the buria Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2-1 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pi 24 hours after death. Funeral Director: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tive of certifier 2 0 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Rui long 32. Registrar's Signature 31. Date filed Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 895 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 24, 4:00 2010 TULL WHITTINGTON May MARIJEAN STERLING /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset Crisfield Alice Byrd Tawes Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🛛 F Yrs 20, 1919 Maryland \$ept. 90 Director 214-12-6756 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a State 10b. County 1 XYes 2 No Crisfield Directo Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be "natural", or Items 23a 21817 298 Somers Cove Apartments
rital Status 12. Was Decedent Ever in U.S.
Armed Forces? Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Specify: White 1 ☐ Yes 2**X**☐ No Baltimore, Maryland 21215-0036 þ 3

Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) sort, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fi lealth and Mental H Is marked Dollie Sterling Edmund Davy Tull ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau once. 6514 52nd Avenue, N.E. - Seattle, Washington 28115 William Whittington (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Episcopal Cemetery 5/29/2010 |Marion, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign in Funeral Service Lige & 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 HEIMER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) been signed by the should be detached Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Onknown SCVD 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined or A 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, Hall Hishway, Crisfield, MD 218/7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kacum bun ethen Vyai 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:50 A. M Will; ams Joseph May 2010 Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Crisfield Somerset Nursing 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 🛣 M 2 🗆 F 218-34-8256 73 15,1937 Maryland Director Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Crisfield Director Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 76399 U.S. A 71817 Asbur Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black <u>ک</u> 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "ns any injury or other traumatic perce. Elementary/Secondary (0-12) College (1-4or 5+) Burial Vault Co. Laborer 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Richard Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , Crisfield, md. 71817 Joseph L. James - Son Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Williams family Cometery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Cove Cv. Wand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed CANCER COLON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2000 No this certificate | 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending To the Hosp...
within 24 hours after ce...
To the Funeral Director: After Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hickway, Hall 201 Kammoun athan.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 29. 2010 2:30 A Κ. Yang Poong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Examiner #421 Oxon Hill 6482 Bock Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Feb. 9, Days Hours Min. 1**x** x M 2 □ F T941 Korea 079-68-7350 69 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2XNo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral with 23a USA 6482 Bock Road #421 20745 items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. þ 1 Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: Korean 1 ☐ Yes 2x No Specify: 3 Widowed 4xXDivorced Completed Year or Dates permit. Page 1 and 2 should be flied within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Self Employed Liquor Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 6482 Bock Road #421 Oxon Hill, Maryland Chong O. Ogbe / Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Resurrection Cem . 06/03/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George P. Kalas Funeral Home P.A. 22. Name and Address of Facility 21. Signatur f Funeral Service Licensee 6160 Oxon HIII Road Oxon HiII, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILE DUCT CANCER Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Division of Vital Records, cate has been sig page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
Yes 2 X No Physician; The law certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5x Residence 6 Other (Specify) 2 X XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Hospital or Attending 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours or To the Funeral Completed filled Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ayapalme M.D. 6/2/2010 D0057465

State

31. Date filed (Month, Day, Year) **JUN 0 3 2910** 

32. Registra's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print).

N.S. Kajapakse MD 2835 Smith Ave. S235 Baltimore, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 9.25 PM 2010 Saiah Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MD 21061 Arundel Glen Burnie Aune Baltimore Washington Medicol Cente If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 🛛 M 2 🗆 F Maryland Director 212-85-0419 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2 No MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21144 1814 Lorgnette Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jasmyne S. Avery Chuckie McGuire, Jr. :. Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 Lorgnette Court Severn, Maryland 21144 James E. Avery / Grandfather 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State ь injury 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery : 06-14-2010 Crownsville, Maryland Funeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 icens Part 1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6 mountage disease hronic intiltrative Sequentially list conditions, If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed stemic organ Storag that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Gaucher disease Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be ( encephaloga thy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 autopsy performed? Cacheria 1 Yes 2 No Anemia Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မှ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. n 24 hours after death le Funeral Director: A bleted filled in by the fi Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Invsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 0018249 June who completed cause of death (Item 23a) (Type, Print) David Valle, H.D., 145titute 0/ 519 BRB 733 N. Broadway Ba Ltic Hopkins Hospital 32. Registrar's gnatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1000A M Oil 2010 Medical give street and number) 4b. Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Numbe 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location, 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director as rington Yes 2 No 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral d 000 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 7/ 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed ac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. life\_DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domes permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th of Health and Mental Hygie If item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bornal 2 Cremation 3 Removal from State cemetery, crematory or other place, MARY 4 Donation 5 ☐ Other (Specify) Sig tre of Funeral Service Licer ea 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final √hysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna
 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 2 🔀 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🔀 No ٩ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 2 No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie D465 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month) Ra

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gerald M. Brenner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 10, 2010 0235 hrs **Medical Examiner** Gerald Brenner 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 701 Edmonson Avenue Room 19 Catonsville If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) Funeral oreign Months Davs Director Country) MD 216-28-9369 1XM 2 F 82 01/17/1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits i, 10b. County 10a, State 1 X Yes 2 No 28a-f show Montgomery Potomac or items 23a or 28a-f shomust be notified at once. permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14018 Welland Terrace United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 3 Widowed If Yes, Give Year 1951-1953 1 Yes 2 X No specify: 4 X Divorced Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **3altimore, MD 21215-0036** 1 Salesman Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Nathan Alexander Brenner Be Katie Dansicker 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Sapperstein / daughter 14018 Welland Terr. N. Potomac, MD 20878 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Arlington Chizuk 1 X Burial 2 Cremation 3 Removal from State 06/12/2010 Baltimore, MD Donation 5 Other Specify Amunŏ Cemetery 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licensee Edward Sagel M00910 1091 Rockville Pike Rockville, N

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart M00910 MD Approximate Interval **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760 23c. If yes, outcome of pregnancy 23d. Date of deliven IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by δ 1 Yes 2 No 3 Probably 4 ✔ Unknown Dementia Completed has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performe death? Yes 2 ✔ No certificate director, page Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other4 Nursing Home 5 Residence 6 🗸 Other: Scene this Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 1 V Natural n 24 hours after death.
c Funeral Director: A
letely filled in by the fu 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 10, 2010 PAMELA SOUTHALL

Registrar DHMH 17 Rev 1/2001

OCMF 2006

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registr

's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day Y

Physician /Medical Examiner

physician and sthe burial-trans

as attending |

signed by the a d be detached f

page

certificate

within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760, こ

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

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Completed

Be

2

DC

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event the Mental Industrial 
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4☐Pregnant at time of death ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No ဥ 27. Manner of Death 28a. Date of Injury Medical Certification: 1 Natural
2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation 6 Could not be determined 3 □ Suicide 4 Homicide

000270	JUJI GCOIGIA AVE. NW	washing con, DC 200.
cations that caused the death. Do not e cause on each line.	enter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
Acute Respir	atory Failure	24 Hours
Due to (or as a consequence of):		
Acute Cardio	vascular Accident	3 Weeks
Due to (or as a consequence of):	on	5 years
3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 I Medical Examiner: On the basis of examination and/or investigation in the cause of the caus

D24535

(Check only one)	2 Medical Examin	er: On the basis o and manner st	f examinatio <b>n</b> and/or investig ated.	ation, in my opinion, death occurred at the tir	ne, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	00		29c. License number	29d. Date signed (Month, Day, Year)

29d. Date signed (Month, Day, Year) April 22,2010

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7700 Old Branch Ave. #C101 Laxmi N. Berwa, MD Clinton, MD

Registrar

L

31. Date filed (Month, Day, Year) JUN 172010

29a. Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2/010 DAVID BESS, SR. JYNE 10, 10:00 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Au<sup>(Month, Day, Year)</sup> 927 Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1 √ M 2 □ F Country)Florida 225-20-6319 82 Director Yrs Usual Residence of Decedent or 28a-f shove notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1 Yes 2 XXo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 11521 Basswood Court 20708 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 XXes 2 \( \text{No.} \) No \( 1946 \) 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XXMarried þ Maryland 21215-0036 1 ☐ Yes 2 XXVo Specify: 3 Widowed 4 Divorced Specify: "natural" Completed Black -1976Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than "I other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 1 year Military Police United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Junnious Bess Amie Faison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11521 Basswood Court David Bess, Jr. Laurel, Maryland 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or ot Date 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State West Arundel Crem. 6/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, PA. / M00770 Laurel, Maryland 313 Talbott Avenue 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 4 Onset and Death Weeks Physician/ Metastatic Lung Cancer disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and dedetached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 No 3XXProbably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? Abdominal Aortic Aneurysm page 2 this certificate has autopsy performed?

Yes 2 XXIo 1 Yes 2 XXo ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 은 1 ☐ Yes 2 🗓 📉 💢 🗸 🔾 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how Injury occurred (Month, Day, Year) 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D25430 June 10, 2010 30. Name and address of pe rson who pleted cause of death (Item 23a) (Type, Print) John MargoZis, M.D. 13952 Baltimore Avenue 20707 Laurel, Maryland 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D2010 Physician/ June 13. 3:00 рм Beynon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Aurora Ct. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 93 Yrs. Funeral Months Days Hours (Month, Day Year 1 D M 2 MaryTand 477 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extensive must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10a, State 10b. County Director Berlin MD 1 Yes 2 K No Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 8 Aurora Ct. 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Bank Commission Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည O'Neill Myrt1e Be11 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 416 Riverdale Rd., Severna Park, MD. 21146 Michael E. Campbell (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6/17/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21, Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Sent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORONA BU scase Physician/ disease or condition resulting in death) Medical Examiner equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate has performed Yes 2 1 🗌 Yes 2 🗆 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home ٩ 2 5 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dear 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tile of certifier to completed cause of death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 7/2009

State Registrar

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		1 - State Registrar				Ce	rtificate of	Death	F	Reg. No.			
Physicia	an	1. Decedent's Name (First, M.	liddle, Last)						2. Date of Dea Month	th Pay 12	Year	3. Time of Death	
/Medic		Margaret	Rose		Carlu	C1	T		June	1	2010	9:15 A M	
Examin	er	4a. Facility Name (If not instit	_					r Location of Death			4c. County of Death		
Euparal		Laurelwood C  5. Social Security Number	are Cer		7. Age (In yrs.		Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h 9. Birthplace (State or Foreign			
Funeral Director		177-30-6992		2 <b>⊠</b> F	75		Months Days	Hours Min.	8. Date of Birtl (Month, Day 04/02)	, Year) /1935	Count	sylvania	
pu >	or	Usual Residence of Deceden 10a, State 10b, Cou			100 0	ty, Town or Lo	nation				140	d. Inside City Limits	
laryla shov						•						1 ☐Yes 2X No	
28a-f	rect	MD Cec	11		Ea	rlevil	LE 10f. Zip Code			10a. Citizer	of What Count		
ours after death with the Marylan ral", or Items 23a or 28a-f show Examiner must be notified at	Funeral Director	16 Pinewood	Road				21919			U.S.A			
death	ner	11. Marital Status	12.	Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14.	Race - America		
or Ite		1 Never Married 2	Married	1 ∐Yes If Yes, Giv	2 📉 No		1 ⊡Yes 2 <b>K</b> No	Specify:	ortican, etc.)	Sn	Black, White, e ecify:		
ural";	d by	3 ☐ Widowed 4 🖾 Divor	rced	Year or Da	ates:	10- P	d#- H1 O				VV.	hite	
in 72 "nat	Completed	(Specity only hi	T	mpleted)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	TOD. KING	of Business/Ind	astry	
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al Hyler I othe	BeC	17. Father's Name (First, Mid	dle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Sui	rname)		
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  Is marked other than "natural", or Items 23a or 28a-f show is marked other than "natural", or Items 20a or 28a-f show raumatic event, the Medical Examinar must be notified at	To	Amedeo		Carl	ucci	1		Millie	Ca	rmella	3	Paradisi	
12 sho		19a. Informant's Name/Relat		,	A. o. se			and Number or Ru					
1 and Healt em 2		Elaine Carlu 20a. Method of Disposition	CC1 / 1	Jaugn			osition (Name of	Drive, A	Date		ion - City or To		
ages ent of t: If It y or o		1 ☐ Burial 2 ☐ Cremat		oval from	State	cemetery, cre	natory or other pla	ce)	4/2010				
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Merlat Hyghen. Internative Important: If Item 27 is marked other than "natural", or eny Injury or other traumatic event, the Medical Examignose.		4 ☑ Donation 5 ☐ Other  21. Signature of Feneral Sen		10556			Lfts Regist 2. Name and Addre	ss of Facility Ar				-	
permi Depar Impor eny Ir		1/1/1/			MI 000			elley Dr.	•		-	•	
		23a. Part 7. Inter the disease shock, or heart failure.	e. or complicati	ions that c	aused the deat		ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition		Me	TAST	4Tic	Pancre	Atic A	denoca	rci N	OMA	Onset and Death	
/Medical Examiner		resulting in death)	(°-	Due to (	(or as a consec	juence of):		Atic A					
Examine	70	Sequentially list conditions,	b		or as a consec		UAL F.	91 LV 1C					
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Due to (	or as a consec	juerice orj.							
te be executed ysician end e burial-transit	Еха	that initiated events resulting in death) Last	c	Due to (	(or as a consec	juence of):							
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leath certificate attending physi i for use as the k	Physician/Medi	IF FEMALE:											
ath ce	ian	23b. Was decedent pregnant in the past 12 months?	23c.	1 Live b	come of pregn birth 2 ☐ Feta	al death 3	Ectopic pregnanc	у		230	. Date of delive Month	ry Day Year	
he de / the a	ysic	1 ∐ Yes 2 No 9 ∐ Unknown		9 ☐ Unkn	nant at time of lown	death 5	Other (specify)						
w requires that the d been signed by the should be detached		Part II. Other significant con	ditions contrib	outing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?	
quires an sign	d by	ANEMIA							1 🗆 Y	es 2□	No 3□ Prob	ably 4 Unknown	
aw reas bee	plet								24a. Was	an 2	24b. Were autor	osy findings available	
stcian: The law certificate has b irector, page 2 sl	Completed								autop perfoi 1 □ Yes		death? 1 ☐ Yes	npletion of cause of 2 □ No	
iding Physician: th. : After this certifica funeral director, i	Be (	25. Was case referred to me examiner?	-					26. Place of Dea	th (Check only o				
Physi this c	ျ	1 ☐ Yes 2 No	Hosp	1 🗆 1	Inpatient 2	ER/Outpatie		4 Nursing H	ome 5 Resid			)	
d <b>ing</b> h. After funer	tion	27. Manner of Death		28a. Date (Mon	th, Day, Year)	Injury	Wor	ryat k?  Yes 2∐No	28d. Describe h	iow injury o	ccurrea		
Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Co	uld not be	28e. Place	of Injury - At h	ome, farm, sti	reet, factory, office	100 100			lumber or Rura	l Route Number,	
al or s afte at Dire	Certification:	4 ☐ Homicide de	torrinios	buildi	ng, etc. <i>(Speci</i>	ty)			City or Tou	vn, State)			
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier  (Check only 2 ded	ifying Physici	an: To the	best of my kn	owledge, deal	th occurred at the to	me, date and place	e, and due to the	cause(s) at	nd manner as s	lated.	
the H hin 24 the F mplete	Medical	one)	9	and man	ner stated.								
<b>6.≱6</b> 8		29b. Signature and title of ce	Viler				29c. Licens	7 5		290. Date s	igned (Month,	Jay, rear)	
		30. Name and address of per	John who come	LI A	a of death (the	m 23a) (Tuno	Print)	2010	-	1 UNG	12	2010	
		linothu	O . Vy	N A	// M_N	1 type,	32 K	John P	LAZA	No.	JAN K	De 19702	
Sta	te	31. Date filed (Month, Day, •)	ear)	32. R	legistra 's Sign	ature /	/ /	3510 Oples P	0) 011	,			
Registr	ar	JU	N172	010	Deneus	J.	facks						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Conway Eleanor Medical 2010 34p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Baltimore <u>3452 Spelman Road</u> Funeral Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year) 2<u>8</u> 11 18 1 □ M 2 👿 F Months Hours Min Director 81 213-26-2930 VA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits NA Baltimore tX☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3452 Spelman Road 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ JYes 2 □xNo Maryland 21215-0036 "natural", If Yes, Give 1 ☐ Yes 2 XNo Specify: Completed 3 ₩ Widowed 4 Divorced Specify: Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker House 2th grade na Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Henry Pinkney Sophia Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Smith-Grandson 3452 Spelman Road, Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ₽ 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King Memorial Park 6/17/2010 Woodlawn, Md 21. Sign of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 0 a 01 disease or condition resulting in death) /ou Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. I signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes ns certificate has been s director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy perform 1 Yes 2 1 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine?

1 Yes 2 No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) upleted filled in by the funeral 27. Manner Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death

To the Funeral Director: A
completed filled in by the fi 2 Accider
3 Suicide Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying, Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 3 pause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Himore, mi 21262 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 2010

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ouentin Coleman Physician/ Dav Month 10:15 AM Medical June 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1104 Woodheights Avenue Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Feb. 19 Birthplace (State or Foreign Country) **Funeral** Days 1 🔀 M 2 🗆 F Director 216-34-4505 73 1937 Washington Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Me & I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1104 Wood Heights Avenue 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. b 1 🗋 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Traffic Office Worker General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ John Henry Coleman Martha Anderson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marlene Coleman Wife 1104 Wood Heights Avenue, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mem. 1 Burial 2 Cremation 3 Removal from State 6/15/2010 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen <sup>22</sup> Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Physician/ month disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIOMYOCATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ORONARY that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\blacktriangleleft$  Residence 6  $\square$  Other (Specify) ပ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1-K Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD JUNE 1120/012:30 PM D41637 J PB 3333 N. CALVERT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 650 RiZK 21218 BACTMOR M 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:22 AM Elsie Ellen Campbell June 2010 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Hospital Prince aure -aurel Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 26, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Min. Hours 1 □ M 2XX Months Days MD 80 Yrs 212-24-4856 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fixed at Evan and one other traumatic event, the fixed at 18 and Director 1 ☐ Yes 2 🔀 No Laurel MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 USA 9523 North Laurel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Bace - American Indian. 1 ∐Yes 2 [2]
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 □Yes 2 No Specify: ፩ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Building Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Bonnie Brown ပ Percy Henry Duck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Campbell/ Husband 9523 North Laurel Road, Laurel, MD 20723 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 12, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Dorsey, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem.Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken Skila 313 Talbott Ave., Laurel, MD 20707 M01053 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Cardiopulmonary hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending pl IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been sign, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 X No 1 TYes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 1 Natural 2 Accident 5 Pending hin 24 hours after death. the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier npletely (Check only one) within To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd. Seungdamrong, MD Laurel Regional Hospital Jason Emergency 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edith May Cromer Medical 2010 June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Futurecare of the Chesapeake Arnold Anne Arundel ial Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/25/14 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min. Virginia Director Yrs <u>218-22**-**2369</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. The 23s or 28a-f show the 27s marked outher than "natural", or items 23a or 28a-f show the traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Severna Park <u>Anne Arundel</u> 10e, Street and Numbe 10g. Citizen of What Country? Funeral 731 Stinchcomb Road 21146 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Ď 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Wallace Emma Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay R. Cromer / Daughter Severna Park, Md. 21146 item 2 731 Stinchcomb Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State . Page 1 ᇹ Important: If it any injury or o 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Cemetery: 6/14/10 Baltimore, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care s that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Inset and Death Physiciani disease or condition Medical resulting in death) Examiner chars Sequentially list conditions, if any cause in the Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transii resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 D 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Haknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 1 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number ho completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Registrar State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Plysician Modical Estimator  Judith Crawford  General Committed  Judith Crawford  Land Character  Judith Crawford  Land Character  Harboro Hospital  Fundad  Director  Plysician  Fundad  Director  Crawford  Land Character  Harboro Hospital  Land Character  Harboro Hospital  Land Character  Land Charact	
Judith  Crawford  4b. City, Town or Location of Death Harbor Hospital  Function  Funct	
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We have the past 12 months?  AMENDED  23a, PII, 27, 28a-f, per ME g904 6/30/10 TT  23d. Date of delivery  1 Yes 2 No 9 V Unknown  AMENDED  23d. Fetal death 3 Ectopic pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Other (Specify) 9 Unknown	
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   1   Unknown   2   Unknown   2   Other (Specify)   1   Yes 2   No 9   Unknown   2   Unknown   3   Ectopic pregnancy   3   Ectopic pregnancy   1   Live birth   2   Fetal death   5   Other (Specify)   1   Yes 2   No 9   Unknown   2   Unknown   2   Unknown   2   This global Title global Titl	
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25. Was case referred to medical 26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Place of Death (Check only one)  28. Place of Death (Check only one)  29. Place of Death (Check only one)  29. Place of Death (Check only one)  29. Place of Death (Check only one)  29. Place of Death (Check only one)  29. Place of Death (Check only one)	
28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work? 28d. Describe how injury occurred	11
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	ity
O.C.M.E. June 12, 2010	ity
30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	iity
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ity

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ERVANDO 2010 5:58 JUNE /Medical /0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE EWTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 24, Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral**  $4^{\text{Year}}$ 1938 Washington DC 1⊠M 2□F Director 220-32-5310 72 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show MD Baltimore Funeral Director 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1215 South Hanover Street 21230 USA ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🛣 No Specify Specify: asian 3 Widowed 4 Divorced "natural" The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) banking industry 12 vice president other traumatic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Winston Senaveratna - friend 600 Light Street Apt 701; Baltimore, Maryland 21201 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state of Funeral Service L 22. Name and Address of Facility Ronald State Anatomy Board; 655 West Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, otheart failure. List only one cause on each line. Maryland 21201 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner ILMONARY CDEMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death signed by the a d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>چ</u> should 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 12 No 2 No 1 Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1XInpatient မှ 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SREGORY F 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22perFH, G904,6/18/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $1\delta^{\!\scriptscriptstyle ay}$ June 20<sup>4</sup>ft Barbara Calvert 8:25 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min May 16, 1945 Maryland Director 214-48-2017 65 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location with the Maryland 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8543 Pioneer Drive 21144 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LPN healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman Hood Ethel Mae Caines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to 8543 Pioneer Drive; Severn, Maryland 21144 Roselle McPherson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place) ematory Inc 6/16/2010 Baltimore Maryland
22 Namy and Address of Facility Crenation Society of MD Inc
299 Frederick Road Baltimore, Maryland 21228 rematory, Inc. 21. Si mature of Funeral Service Licensee Rolland S. Wade, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician/ Examiner Medical resulting in death) Due to (or as a consequence of) CARDIONAS CULAR. YEARLS ATHENOSCUEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE been signed by the attendir should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CHRANIC REMAL FAILURE, CHROSIC 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY DISEASO 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work within 24 hours after death. To the Funeral Director; A Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifie 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D31136 JUNE 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD, BATIMORE, MD 21236 WALLACE MD

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Baltimore. Maryland 21215-0036

			For 1 _ State		State of N	larylan		artment of H		and Me			en en e	
Ag.			Registrar  1. Decedent's Name (First,	Middle. La	st)		Cei	rtificate of	Death		2. Date of Dea	Reg. No		3. Time of Death
Į.	Physici		The second secon	madio, se	Lottie		V.	Dougla	as		Month June	D	ay Year 2010	
4	/Medic Examin		4a. Facility Name (If not ins	titution, giv	e street and number	r)		4b. City, Town, o	r Location o		June		c. County of Dea	
T			FutureCare	North	point Nur	sing	Home	East	point				Balt	imore Co.
	Funeral	-	5. Social Security Number	6. 5	Sex 7. A	ige (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Birti (Month, Day	h v, Yea	9. Bir	thplace (State or Foreign ountry)
(8)	Director		220-01-0439 Usual Residence of Decede		- III - III	94	Yrs.				June 15	19	915 Was	hington, D.C
	land ow		10a. State 10b. C			10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
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	r dea	Funeral Director	11. Marital Status		12. Was Deceder Armed Forces	t Ever in U	J.S. 13.1	Was Decedent of H If Yes, specify Cuba	lispanic Orig	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit	
36	s afte	by Fi	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2X If Yes, Give Year or Dates			1 ☐ Yes 2 ☐ No	Specify:				Specify:	White
9	hour tural	ed b		cedent's E	<u> </u>		16a, Dece	dent's Usual Occup	pation	-		16h	Kind of Business	
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pu	oe file al Hy d othe	Be (	17. Father's Name (First, M						18. Mothe	r's Name (	First, Middle,	Maide	en Surname)	
yla	ould by Ment	ဥ	Millard						Lo	ttie	Owings	3		
Jar	12sh nand rism raum		19a. Informant's Name/Res Susan Pende					ng Address (Street						
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ō	ages nt of I t: If ite		1 ☐ Burial 2 ☐ Crem					sition (Name of matory or other place						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at once.		4 Donation 5 01			nti L	22	e Park Ce	ss of Facilit	v	/2010			Maryland
B	Dep Imp any		PIR	,	( (	'a	( )   Di	uda-Ruck 1922 Wise	Funer	al Ho	ome of	Dur	ndalk, I	nc. 21222
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10	Examiner	_	Sequentially list conditions		b									
,0	ed sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (or a	s a conseq	quence of):							
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Вох	th cerr endin	M/us	IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, outcom 1□Live birth			Ectopic pregnancy					23d. Date of de	livery
	ed for	sicia	in the past 12 months 1 ☐ Yes 2 ☐ No	?	4□Pregnant 9□Unknown			Other (specify)	y 				Month	Day Year
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Division or Vital Records,	Attending Physician: The law requires that the death certif roeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	þ	ILTW	onditions (	contributing to death	Dut not res	sulung in the u	nderlying cause giv	ren in Part I.		23e. Did to			o the cause of death?  robably 4 □Unknown
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ta	in: T		25. Was case referred to n	nedical					OC Disease	of Death	1□ Yes	2		2 □ No
>	yslcia is cert direct	To Be	examiner? 1 ☐ Yes 2 No	TO GIT OCT	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatier	nt 3 DOA Oth			(Check only o		6 □Other (Spe	voja)
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įį	or Att fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	Could not b determined	Zoe. Flace of i	njury - At h etc. <i>(Speci</i>	iome, far <i>m</i> , str ify)	eet, factory, office		28	Bf. Location (S City or Tox	Street a	and Number or F	ural Route Number,
	pital ours a ceral C		29a. Certifier 12 Ce	wife days. Di	nysician: To the bes	at at many land		b opposed at the at						
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Me	edical Exa	miner: On the basis and manner:	of examina	ation and/or in	vestigation, in my	me, date an opinion, dea	id place, ar ith occurre	d at the time,	date a	(s) and manner a and place, and du	s stated. e to the cause(s)
_	To th within To th	Me	29b. Signature and title of	certifier		, ;		29c. Licens	se number.	_		29d. D	Date signed (Mon	th, Day, Year)
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	2		30. Name and address of p		completed cause of	death (Iter	m 23a) (Type,	Print)	al Ri	2 5	t= 150	>, (	abu t	Burn's Hr
	Sta Registr		31. Date filed (Month, Day, JUN 172)	Year)	completed cause of and on 32. Regis	strar's Signa	park	,				1		· · · ) ·-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12 Month Year **Physician** Suttles Dominick June 11:05 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Assisted Living Well Compassionate Ca Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Aug. 02 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1934 Months Days Min Hours 407-40-2664 1 ■ M 2 🔀 F Aug. KY **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandue. 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 Howard Circle 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ğ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William V. Suttles Nora Ferguson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita G. Kocka 550 6th Street, Pasadena, MD 21122 (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June Date 21 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disshock, or heart failu ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Onset and Death Immediate Cause (Final guamous **Physician** cell Carcinoma disease or condition resulting in death) /Medical Du to (or as a consequence of): Sept 2009 **Examiner** Sequentially list conditions, if any build in the Limm list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 DNo 1 ☐ Yes 2) 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 155,582 Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 📉 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No neral Director: / investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manual CRAF

**ORIGINAL** 

29c. Liçense number

K686053

271 Wess Pasaden Rd

29d. Date signed (Month, Day, Year)

Millersville MD 21168

061510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:50 AM 2010 /Medical June 4a. Facility Name (If not institution give street and 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince George's -aure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕅 F Director 187-24-1645 77 28, 1932 Pennsylvania June Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be profilled at Director 1 ☐ Yes 2 X No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20724 Horsehead S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No White Specify: 3 ♥ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. 12th Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) (unknown) ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 7506 Montevideo Court, David A. Coligan/Son Jessup, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 6/16/2010 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. price & 20707 313 Talbott Avenue, Laurel, MD 23a. Party. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus you each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intrabdomina **Physician** / /Medical Due to (or as a consequence of): Examiner Congestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Obstructive and burial-trai Due to (or as a consequence of) P.O. Box 68760 ned by the attending physician detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Peritoniti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? has certificate 2 **N**0 Division of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2MNo 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending n 24 hours after death.

• Funeral Director: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and certifie 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar 30. Name

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

7300

and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional

DHMH 17 Rev 1/2001

State

Registrar

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHAI

₱32. Registrar's Signature

HASSAN

KHALID

31. Date filed (Month, Day, Year)

JUN 1 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 200 AM 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Square Rosedale FRANKLIN Hospital Center (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. 18-36-835 **Director** items 23a or 28a-f show 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No ex 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral I 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ō 21215-0036 1 Yes 2 No If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry DO NOT use retired) onday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) ပ္ 19a. Informant's Name/Relationship /Tvoe. 19b. Mailing Address (Street and Number or Rural Route Number, ouce Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 2 Cremation 3 Removal from State Other (Specify) 21. Signature of Funeral Service Lig Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death Physician thmic Fata archy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death n signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 124 hours after death.

e Funeral Director: After this certificate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work' 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined **Medical** 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 06 00553 15 2010 30(Name and address of persor who comp eted cause of death (Item 23a) (Type, Print) 9000 Fra do-fone-servy Modic-e Ø BL 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

PAMIENT KNOWN AS PEARL DANIELS

			State of Maryland / De	partment of Health and N	-		10070		
			101	ertificate of Death	, ,	g. No.	8919		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death		
	Medic	al	Pear1 Danie1s  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June	7 2010	15:59 PM		
A <sub>ي</sub> ر	Examin	er	SINAL HOSPITAL OF BALTIMORE		CITY	4c. County of Deat	n		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min	8. Date of Birth	9. Birt	hplace (State or Foreign		
	Director		212-56-8311 The Market of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Market Of Decedent 1 The Marke		pct 30°,	1948   Nor	th Carolina		
	yland f shov ed at	tor	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits		
	e Mar r 28a- notifie	Sirec	MD Baltimo				1 ☒ Yes 2 ☐ No		
	vith th 23a o st be	<b>Funeral Director</b>	2507 Park Heights Terrace	10f. Zip Code 21215	10	g. Citizen of What Co USA	untry?		
	items	Fun		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame			
36	after o		1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ★ No If Yes, Give	1 Yes 2 X No Specify:	nican, etc.)	e, etc. ck			
8	hours natura ii-al E	Completed by	15. Decedent's Education 16a. De	cedent's Usual Occupation	Specify: black				
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d 21	ed with Hygier other t	Be C	9 0 c1	ustodian	- (Final Middle Ma		on & Parks		
lan	be file lental l rked c	70	Acey Hendricks		e (First, Middle, Ma : Williams	-			
Baltimore, Maryland 21215-0036	should and M			alling Address (Street and Number or Run 507 Park Heights Te					
re,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.					Oc. Location - City or			
imo			4 □ Donation 5 ☑ Other (Specify) in State	rematory or other place)		,			
Balt	permit Depart Import any inj		21. Sign of uneral Service Licensee Romand S. Wadar irector	<sup>22</sup> State Anatomy Boa Baltimore, Maryla		est Balti	more Street		
			23a. Par 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between		
	Pnysician Medical	i n	Immediate Cause (Final disease or condition resulting in death)	FAILURE			Onset and Death  5 days		
-	Examiner		Due to (or as a consequence of):  OBSTRUCTIV			7 days			
		iner	Seque, tally liet out afficiency if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):				- 0		
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	LUNG CARCIN	OMA		10 months		
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876	tificate ng phy as the	Med	IF FEMALE:						
9 xc	ath cer attendii or use	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death	Ectopic pregnancy		23d. Date of del Month	delivery  Day Year		
Ö.	the dea	hysid	1  Yes 2 Mo 4 Pregnant at time of death 5 9 Unknown	i U Other (specify)		111011111			
Division of Vital Records, P.O. Box 6876	requires that the death certificate been signed by the attending physhould be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in th PIABETES MELLITUS, HYPERTENSION		23e. Did tobacco use contribute to the cause of death?  11 Yes 2 \( \subseteq \text{No 3 } \subseteq \text{Probably 4 } \subseteq \text{Unkn}				
ords	require been s should	leted	THE STORY TO	DN , HYPERUPIDEMIA			topsy findings available		
Şecc	he law te has age 2 s	ошр			24a. Was an autopsy performe	prior to death?	completion of cause of		
Fal	sian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check	1  Yes 2 k only one)	☑ No  1	2 E NO		
Ţ	Physic this coral dire	욘	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 28a. Date of injury 28b. Time			ce 6 Other (Spec	ify)		
o uc	nding ath. : After e funer	cate	1 Natural 5 Pending (Month, Day, Year) injury		28d. Describe how	injury occurred			
visio	or Atter frer des irector n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree	et and Number or Rui State)	al Route Number,		
Ö	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	h occured at the time, date and place, an			ted.		
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 3 ☐ Medical Examiner: On the basis of examination and/or involved only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledg 29b. Signature and title of certifier	estigation, in my opinion, death occurred a	the time, date and I	place, and due to the o	cause(s) and manner stated.		
	<b>6</b> ≥ <b>6</b> 0		290	Jone,					
			Jheidendra Just MD.  30. Name and address of person who completed cause of death (Item 23a) (Type	RES - 000		ر ماران	2010		
			SHAILENDRA PINGH, MD, SINAI	HOSPITAL OF BAL	TIMORE				
	Stat Registra		SHAILENDEA FINGH, MD, SINAI  31. Date filed (Month, Day, Year)  32. Register's Signature  JUN 172010  Annua J.	ball					
			WILL COIL WORK A	(7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 Day 2010 Pear Physician/ June 6:38 A M Wavne Allen Dorman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 6310 Southwood Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Country) Maryland Funeral Days Oct. 20 Hours Year 1953 Director 219-58-0897 56 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No Nottingham MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral USA 21236 9 Hickory Nut Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service etter Carrier. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Effie Virginia Couplin James Richard Dorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hickory Nut Court; Nottingham, MD 21236 wife Darlene M. Dorman Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 🏠 Cremation 3 ☐ Removal from State Hilltop Service Corp.: 6/16/2010 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 1 Service 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ one month disease or condition resulting in death) Medical Due to (or as a consequence) Examiner Secure tielly list over this as Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the aid be detached for 1 ☐ Yes 2 ☐ Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Alcohol abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Vital 26. Place of Death (Check only one) completed filled in by the funeral director, sister-in-law's home Other: 4 Nursing Home 5 Residence 61 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death, Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058860 JUNE 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTU, MD CALVERT STREET, SUIK 555 MO 3833 SHANN DHILLION State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Josephine Falls May  $P^{M}$ June 2010 11:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Health & Rehabilitation Glen Burnie Anne Arundel 5. Social Security Number g. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Jan. 10, <sup>Year</sup>201<u>0</u> 1 M 2 TF Marvland 213-26-7720 83 Director Usual Residence of Decedent 10a. State 10b. County be filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Howard Elkridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5727 Landing Road 21075 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed within ritment of Health and Mental Hygiene ortant: If item 27 is marked other th njury or other traumatic event, the Teacher Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Sacker ည Sophia Prucha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marty Falls permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. (Son) 5727 Landing Road Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Meadowridge Memorial Park 6/25/10 4 Donation 5 Other (Specify) Elkridge, Maryland Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each Immediate Cause (Final the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death aedea Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated so or injury) Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 21 No Day Year Month Pregnant at time of death 5 Other (specify) g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by W 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an after death.

Director: After this certificate has page 2 s prior to completion of cause of death?

1 Yes 2 No autopsy performed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Nursing Home 5 - Residence 6 - Other (Specify) Hospital 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 | No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 06-13-2010 **Physician** 1:26 Рм John W.E. Fendlay /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Catonsville Baltimore 1403 Pleasant Valley Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-06-1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1**X** M 2□ F MD 212-09-5374 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be refulfed at 1 □Yes 2 No Director Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1403 Pleasant Valley 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Businessman marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othnany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Marie Brengle James Fendlay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8242 Academy Road, Ellicott City, MD 21043 Patrick Fendlay- son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park | 06-17-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Li MMP, Inc., 7250 Wash Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final braestive hear Physician /Medical resulting in death) **Examiner** bronaru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence f): Examine burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year for Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ned by the a P.0. 9 I Inknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔁 No Hospital: ဂ္ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred re Hospital or Attending Pl n 24 hours after death. Ie Funeral Director; After the 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) In. Catonsville, mp Ractat Maiden 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

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Funeral Director	*	6. Sex 212-60-6618		e (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Da		Min.	th(MM/DD/YYYY)	Foreign Country) WV
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ᅙ	1 Never Married 2 Married 1		t Ever in U. ? XX No	If Yes		an, Mexican, P	? ( Specify Yes or No uerto Rican, etc.)	14. Race White	-American Indian, Black, , etc. White
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re, M s 1 and 2 f Health If item 2	ŀ	20a. Method of Disposition  1 X Burial 2 Cremation 3		tate	Place of Dispositi crematory or other	r place)	1	Date 6/18/2010		City or Town, State
Itimo nit. Page artment o ortant:	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee		08	ak Lawn	me and Addre	ry ss of Facility Funera	al Home of	1	, Inc.
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Physician Medical Examiner	ł	failure. List only one cause on each Immediate Cause (Final disease a. Ca	rdiac Arrhyt	hmia						Between Onset and Death
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Box e death the atte	Physi	1 Yes 2 No 9 Unknown	9 Unknown	th but not	resulting in the ur	iderlying caus	e given in Part	23e. Did	tobacco use contr	ibute to the cause of death?
P.O. es that things igned by oe detach	≦	Part II. Other significant conditions of Hypertensive Cardiovascula						1Ye		Probably 4 🗸 Unknown
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Foneral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of (Specify)	Injury - At I	home, farm, stree	t, factory, offic	e building, etc	. 28f. Location or Town,		per or Rural Route Number, City
ne Hospita n 24 hours ne Funera	cal Ce	4		my knowle	dge, death occuri and/or investigati	ed at the time on, in my opin	, date and place	ce, and due to the cau	use(s) and manne e and place, and	or as stated. due to the cause(s)
To the within To the comple	Medical	29b. Signature and title of certifier	nd manner state	d.			ense number			ned (Month, Day, Year)
		Carol H	alla	Lu		О.	C.M.E.		June 16, 2	2010
3		30. Name and address of person who co Carol Allan, MD Assistan	mpleted cause o		m 23 <b>a</b> ) 111 Penn S	Street, Balt	imore, MD	21201		
Si	ate	31. Date (lied (Month, Dan Your)	32. Regis	tran Signa	tall					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ReNO Ru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VERNA 101NG PUNDE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/22/1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖾 F 89 Director 212 28 5434 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at Director 1 ☐ Yes 2K No Maryland Anne Arundel Glen Burnie 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1809 Norfolk Road Items 23a 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 🗶 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ∐Yes 2**X** No Specify \$ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Inc. Elementary/Secondary (0-12) College (1-4or 5+) 8th Assembly Work Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Opp Livesay Gertrude Harrah ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Fleshman / Granddaughter 1809 Norfolk Road Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 06/14/2010 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 namerollally 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TI-INFAPCT XEKR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by LYPERTENSION ficate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Division of Vital 1 ☐ Yes 1 ☐Yes 2 ☐No After this certification funeral director, r Be 25. Was case referred to dical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☐ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the f

> State Registrar

29a. Certifier

30. Name and a

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GAEL

DHMH 17 Rev 1/2001

32. Registrar's

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Medical ସଦ/ଠ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Imore VA Medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours th Bay Director Usual Residence of Decedent 28a-f show 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Walker USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces:
1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Klack Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ry/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည terquson Minnie Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ife O. terauson alker Avenue Baltimore laryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other p 4 ☐ Donation 5 ☐ Other (Specify) UWINGS MILLS Marylan rore. 21. Signature of Funeral Service 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rena disease or condition Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Neart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown COLT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Tyes 25. Was case referred to medical examiner?
1 🗆 Yes 2 🗶 No Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 5 Pending e Hospies. In 24 hours after death. The Funeral Director: Aft work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 1871728709 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

e Gibson MD

Registrar
DHMH 17 Rev 7/2009

Greene Street

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day THOMAS FLAHERTY 11:21 P M JOHN JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 719 Rainbow Court Edgewood 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 ★ M 2 □ F Months Days Hours Min. Year Director 218-50-3039 64 1946 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford <u>Edgewood</u> 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 719 Rainbow Court 21040 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 72 hours after 1 Never Married 2 Married 1 XYes 2 If Yes, Give Year or Dates 2 No 21215-0036 1 Yes 2 No Specify. "natural" Specify: 3 Widowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Assembly Installer Aircraft Manufacturer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be f ည t. Page 1 and 2 should by rtment of Health and Mer rtant; If item 27 is marke William Francis Flaherty Helen Irene Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katharine A. Flaherty / Wife 719 Rainbow Court, Edgewood, MD 21040 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place) ō 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) <u> Hagerstown Crematory</u> 6**-**17**-**10 Hagerstown, Maryland 22. Name and Address of Facility
McComas Funeral Home, . Signature of Funeral Service Licensee achleer Dantivascu 1317 Cokesbury Road, Abingdon. MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gar line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Du Examiner Scale ricilly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed the burial-transi CI and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2-☐ No Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) this 27. Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar only one

31. Date filed (Month.

29b. Signature and the of certifier

DHMH 17 Rev 7/2009

pleted cause of death (Item 23a) (Type, Print) 1308 Bu

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

e numbe

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Ragistrar	State of	Marylaı		artmen				lental Hyg	jiene	010	189	88
	Physic	an	1. Decedent's Name (First, Middle, Las	1)							2. Date of Dea Month	th Day	Year	3. Time of	Death
	/Medi		Sterling Frisby .	Jr.							June	5	2010	7:35	$P^{M}$
1	Examir	ner	4a. Facility Name (If not institution, give						Location of	of Death			ounty of Death		-
			Julia Manor Heal					erst					shingt		
	Funeral Director		5. Social Security Number 6. Se 214-05-8010	x 7. \$M 2□F	Age (In yrs. 91	. last birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	8. Date of Birth (Month, Day Aug 15,	Year)	9. Birth	place (State o.	r Foreign
			Usual Residence of Decedent		91	110.		j			Aug 15,	1918	Mar	yland	
	yland Now		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1.	Od. Inside Cit	ly Limits
	Mar a-f at	į	MD Washing	gton	I	Hagerst	own							1 🗌 Yes	2 No
	or 28,	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizer	of What Cou	ntry?	
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	dea .	Funeral	11. Marital Status	12. Was Decede	nt Ever in U						ecify Yes or No-		14. Race - American Indian, Black, White, etc.		
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al	Menta Menta arked artic ev	ToB	Sterling Frisby	Sr.					Eli	zabe	th Davis	3			
ary	shot and M	Γ.	19a. Informant's Name/Relationship (T	rpe, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Number	, City or To	own, State, Zip	Code)	
Σ	and 2 iaith a iaith a 27 is	1	Elaine Dodson -	daughte	r	317 E	ast K	irby	Str	eet;	Tampa,	Flor	ida 336	04	
Ore	of He of He fitan r oth		20a. Method of Disposition	3		Place of Dispo cemetery, cren	sition (Nam	ne of ther place	e)	C	ate	20c. Locat	ion - City or To	wn, State	
<u>Ĕ</u>	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☑ Donation 5 ☐ Other (Specify,		16	,	, ,	,	1						
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than any injury or other traumatic evant, Ita Magnes.		21. Signature Euneral Service Licens Ronal d S	Wade, Vi	recto	r 22					rd; 655		Baltim	ore St	reet
			23a. Palt1. Enter the disease or comp shock, or heert failure. List only o	idations that caus	ed the dea	th. Do not ente	or the mode	of dying	, such as	cardiac o	nd 21201 r respiratory arr	est,		Approximate	)
ر ا	Physician		Immediate Cause (Final disease or condition	Co	210	Liona	41	, , ,	ton	4 1	Carlu	A. /		Onset and D	
V.,	/Medical		resulting in death)	Due to (or	as a consec	quence of):	m	~~		<u> </u>	14	0		Tew	ME
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	D :=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):			1						
	and and I-tran	каш	that initiated events resulting in death) Last	c	are	acs 0	ne		ton	5 5			Segr	rel	Years
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×	The law requires that the death certific sie has been signed by tha attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE:	3c. If yes, outcom	ne of prean	ancv									
Вох	attendin for use	ciar	in the past 12 months?	1☐Live birth 4☐Pregnant	2 Feta	al death 3	Ectopic pre					230	. Date of delive Month	_	ear
P.O.	thet the de ed by tha a detached f	hysi	1	9□ Unknown			outer topo	//							
	res ther igned to be deta	by P	Part II. Other significant conditions co		but not res	ulting in the un	derlying ca	use give	n in Part I.		23e. Did tob	acco use	contribute to the	e cause of de	ath?
Vital Records,	w require been sig should b	B	Caecinom	9	1103	fale					1 □ Y€	s 2 🗆 N	lo 3□Prob	ably 4	nknown
ပ္ထ	aw requ	Completed		V							24a. Was a	2	4b. Were auto	psy findings a	vailable
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Ta Ta	certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only on	el No	1 🗆 Yes	2   NO	
	Attanding Physician: r deeth. ector: After this certific by the funeral director.	၉	1 Yes 2 No	lospital: 1 🔲 Inpa	tient 2 🗆	ER/Outpatient	3 DO				ne 5□Reside		Other (Specifi	()	
0 _	ding P. h. After ti funera		27. Manner of Death  1 Matural 5 Pending	28a. Date of In (Month, L	jury Day Year)	28b. Time of Injury	28	c. Injury Work	at		8d. Describe ha				
<u> </u>	ttandi Jeeth. tor: A the fu	cati	2 Accident investigation				М		es 2□N	10					
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;	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edicai	29a. Certifier 1. Certifying Physical Check only 2 Medical Exami	ner: On the basis and manner	UI GAGIIIIIId	wiedge, death ition and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, deat	d place, a h occurre	and due to the ca ad at the time, da	iuse(s) and ite and pla	d manner as st ice, and due to	ated. the cause(s)	
	To To	Σ	29b. Signature and title of pertifier					License			25		gned (Month,		
			0,1	つり				ノン	5-49	7	-	6	.7.1	0	
	1		30. Name and address of person who co	mpleted cause of	death (Item	n 23a) (Type, F	Print)		11	11	5050		MA	217	L
سفي	Stat		TANVIR A. PAS 31. Date filed (Month, Pay Year) 72	32 Marie	trar's Signa	atura A	MIL	11.	71.	796	1/2/2	WN	, 212	- / /	70
T. A.	Registra	ar .	JUN 1720	10 Light	ecis"	1-18									1

DHMH 17 Rev 1/2001

10-04474 Malik Griffin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar		Certi	ificate of	Death				Reg. No.		
Physic Medical Exam			Mali		Griff	in			2. Date of D Month June 13	eath Day Y	ear	3. Time of Death 0300 hrs
7		4a. Facility Name (if not institution Johns Hopkins Bayvie			4	b. City, Town, Baltimore		n of Death		4c. County	y of Death	
Funera		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Y		der 24Hrs.	8. Date of	Birth(MM/DD/YYY	YY 9. Birt	hplace (State or
Director		217-87-2815	1 <b>Ҋ</b> M 2☐F		Yrs.		ays Hou		7	8-2010	Foreign	n MD
any		Usual Residence of Decedent  10a. State 10b. County		Inc. City T	own or Location			_				
<b>*</b> .		1 110	na		timor							10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once,	턍	10e. Street and Number	II d	Baı	CIMOL	10f. Zip Code				10g. Citizen of V	(h-1-0	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygenes, and with it Hiem 27 is marked other than "natural", or items 23a or 28a-f shown or other traumatic event, the Medical Examiner must be notified at once.	I Director						202			US A		ury?
ath wi items	Funeral	11. Marital Status 1 X Never Married 2 Ma	12. Was Dec	cedent Ever in U.S. orces?		Decedent of F s, specify Cub	lispanic Or an, Mexicai	rigin? ( Spe in, Puerto R	cify Yes or Rican, etc.)		e - Americ	can Indian, Black,
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	9 B	Curtis S. (		- 9	19b. Mailing	Address (Stre	Charles and the second			Newby umber, City or Tov	um Stata	Zin Codo)
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental I tt: If item 27 is marked other traumatic event,	Π	Curtis S. Gi	ciffin-F	ather	4919	Goodi	now E	Road	Bal	to, MD	212	06
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:		1 Burial 2 X Cremation	3 Removal fro	om State crei	matory or othe		emetery,		Date	20c. Location		
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Ball permit Depart Impor		21. Signature of Echeral Service	The Contract of the Contract o	7		me and Addres				ast F/F Balto		D 21202
Physician		23a. Part I Enter the disease, or o	complications that ca	used the death. Do								Approximate Interval
/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease	on each line.	unexpla								Between Onset and Death
Examiner		or condition resulting in death)		consequence of):	1							
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8760, tificate be exe ng physician a	/Mec	IF FEMALE:	23c. If yes, o	utcome of pregnan	icy					23d, Date of	delivery	
യ ∄ ജെ		23b. Was decedent pregnant in the past 12 months?	I L Live bit	rth ant at time of death		death 3	Ectopic	c pregnanc	у	Month	Da	y Year
Vital Records, P.O. Box 6 hysician: The law requires that the death certhis certificate has been signed by the attendi director, page 2 should be detached for use.	Physicia	1 Yes 2 No 9 Unkn			5 Othe	(Specify)						
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staff death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		27. Manner of Death  1 Natural 5 Pendin	28a. Date of (Month, D		b. Time of Inju		ry at Work		d. Describe $\mathrm{nk}$	how injury occurr	ed	
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4	-	39. Name and address of person wh	ho completed augo	of death /ltom 22-		0.0.	••			June 13, 20	710	
Y		Russell Alexander MD.		edical Examine		enn Street,	Baltimo	re, MD 2	21201			
		31. Date filed (Month, Day, Year)		istrar's Signature	4 1	ukel		OCME				
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ Virginia Ann 2010 06:25 PM Garriott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Health & Rehab Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) March 08 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min. 1 M 2 Dx F Hours Director 215-09-9179 68 MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant I item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10b. County 10c. City, Town or Location Director items 23a or 28a-f s ler must be notified 1 Yes 2 No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8361 Elvaton Road USA 21108 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten edical Examiner 11. Marital Status Armed Forces Black, White, etc þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No White Specify: Completed 3 Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 6 Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marvin Zepp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8361 Elvaton Road, Millersville, MD 21108 Genevieve Bury (sister) 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) June Date 19 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State **Department** Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility alame and Address of Facility
Stallings Funeral Home,
3111 Mountain Road, Pasadena, MD 21122 P.A. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 No a  $\square$  Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Matural 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jo Anne Hower 1:55 PM June 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-2-1938 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 227-50-5289 70 Director Virginia Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4854 Royal Coachman Drive 21075 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Hair Care Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh Coates Evelyn Straley ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4854 Royal Coachman Drive Elkridge, Maryland 21075 Kelley Marianetti (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6-16-2010 | Glen Burnie, MD 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licens Columbia, MD 21045 whi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute chronic **Physician** on /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner vascular disease burial-transit P,O. Box 68760 physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🔲 Yes 2 No 3 Probably 4 ☐ Unknown Completed page 2 should peen CONIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy anemia perforn Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 2 30 Name and address of person was completed cause of death (Item 23a) (Type, Print) 0 Charles 6-101 31. Date filed (Month, Day, Year) 32. Registr r's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Year Μ. Charles Hilker, Jr. 14, 9:00PM June 2010 4b. City, Town, or Location of Death 4c. County of Death Dunda1k Baltimore Co. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min 82 27,1927 Maryland Aug. 10b. County 10c. City, Town or Location 10d. Inside City Limits Dunda1k Baltimore 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? United States 21222 14. Race - American Indian,

1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner Genesis Heritage Nursing Home 5. Social Security Number **Funeral** 212-24-9869 Director Usual Residence of Decedent wouls 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evandreur must be notified at MD 10e. Street and Number 7522 Lawrence Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after death be Department of Heath, and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, Important American in the most page. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ģ Specify WWII 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 6 Years Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisey P. Ketchum ဥ Charles M. Hilker, Sr. 19a. Informant's Name/Relationship (Type. Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7556 Battle Grove Circle Dundalk, Maryland Mrs. Jean D. Reinthaler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation , 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 6/18/10 Dundalk, Maryland 21. Signatur of uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or head failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIO RID-SCLE ROTTLE **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the buria The law requires that the death certificate be Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the a 5 Other (specify) o. 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown ۵. but not resulting in the underlying cause given in Part I. Vital Records, certificate has t rector, page 2 s autopsy perforn 1 □ Yes 2 No or Attending Physician: **Director:** After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To ŏ

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 D No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature

2010

Month

Black, White, etc.

White

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Day

Year

21222

ed addeaths (Irem 83a) (Type, Ring) TIMOR 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

completely .

Medical

DHMH 17 Rev 1/2001

Division

death. after death

Hospital within 24 hours a filled

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene- U | U Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 650 Harold Hopewell LUNE 4a Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Itimore timo re Ð 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, 11 06 9. Birthplace (State or Foreign M 2 🗆 F Months Min Hours Country) 212-70-5957 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3916 West Cold Spring Lane 21215 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes Give 1 Tes 2 No Specify. Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>llth grade</u> na Cook Checkers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Turner Pauline Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Pauline Saunders-Mother 3916 West Cold Springs Lane, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Druid Ridge 6/17/2010 Pikesville, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death Due to (or as a consequence of): s a consequence of:

Physician/ Medical Examiner

permit. Page 1 and 2 should be artment of Health and Me Important: If item 27 is mark

Physician/

Examiner

Funeral

Director

artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at

TAROUT TORNE

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Maryland 21215-0036

Baltimore,

Medical

10a. State

MD

Director

Funeral

Completed by

the attending physician hed for use as the burial been signed by the should be detached has certificate within 24 hours after death.

To the Funeral Director: After this

Division of Vital Records, P.O. Box 68760

or Attending Physician: The law requires

Examine Physician/Medical Completed by Be မ Certificate: Medical

21. of Funeral Service Ligensee 23a. P. rt 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No 1 Tyes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Suicide Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 19 10

DHMH 17 Rev 7/2009

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State

Registrar

West Belvedere

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401

32. Registra Signature

Afzal

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiana

			1 - For State Registrar	State of Mary		epartment of Hea Se <i>rtificate of Dea</i>			ene 2010	18994	
	Physicia Medic		Decedent's Name (First, Middle, La  BETTY LO					Date of Death Month		3. Time of Death 7:15 p M	
	Examir		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or Loc		dire	4c. County of Dea		
			Transitions Heal			Sykesville	е		Carroll		
	Funeral Director		217-34-0020	7. Age (In )	vrs. last birthda Yrs	Months Days H	Under 24 Hrs. 8. lours Min. 2	Date of Birth (Month Day Dril 1	9. Bi 0, 1936	rthplace (State or Foreign ountry) MD	
7	nd how at	_	Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or	ocation				10d. Inside City Limits	
	faryla 3a-fs iffied	ecto	MD Prince	George's	Laure					1 🔀 🌪es 2 🗆 No	
	the N or 28	١	10e, Street and Number	dedige 5	Dadic	10f. Zip Code		10	ng. Citizen of What Co		
	s 23a	<b>Funeral Director</b>	404 Montrose Aven	ue		20707			U.S.A.	,	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2XXNo If Yes, Give Year or Dates.	n U.S. 1	3. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2★No Sp	nic Origin? (Specify lexican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.	
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ylar	id be id Menta arked	2	William F. Rexrot	h			eulah Mec				
e, Maryland 21215-0036	nd 2 shou lealth and m 27 is m		19a. Informant's Name/Relationship (7) Percy Dean Hoak	ype, Print) / son		ailing Address (Street and N 037 Monticell				p Code) 21723	
Baltimore,	. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition  1   Surial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Removal from State		sposition (Name of rematory or other place)	Date 6/21/2		20c. Location - City or Town, State Brentwood, Maryland		
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. Box 68	To the Postula or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ ※ o g ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 1 4 Pregnant at time 9 Unknown			23d. Date of de Month	livery Day Year			
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<u> </u>	sician certifi irector	m,	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※※  2 ※  1 ☐ Yes 2 ※  2 ※  2 ※  3 *  4 *  4 *  4 *  5 *  6 *  7 *  7 *  1  ☐ Yes 2 *  7 *  8 *  9 *  1  ☐ Yes 2 *  1  ☐ Yes 2 *  1  ☐ Yes 2 *  1  ☐ Yes 2 *  1  ☐ Yes 2 *  1  ☐ Yes 3 *  1  ☐ Yes 3 *  1  ☐ Yes 3 *  1  ☐ Yes 4 *  1  ☐ Yes 4 *  1  ☐ Yes 5 *  1  ☐ Yes 6 *  1  ☐ Yes 6 *  1  ☐ Yes 6 *  1  ☐ Yes 7 *  1  ☐ Yes 7 *  1  ☐ Yes 7 *  1  ☐ Yes 8 *  1  ☐ Yes 9 *  2  ☐ Yes 9 *  2	Hospital:		0.1	f Death (Check only				
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LO .	ath. rr Afte	icat 	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year,	) injury	work? M 1 ☐ Yes	ı	DOSONIDE NOW	injury occurred		
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- 1	ne Hospil in 24 hour he Funera	Medical	Coneck / Z   Wedical Examin	ician: To the best of my kn ner: On the basis of examina e Practioner: To the best of	uion and/or inve	esugation, in my opinion, dea	ath occurred at the t	ime date and	slace and due to the c	nueg(a) and manner stated	
_ 5	Vith Com		29b. Signature and title of certifier	_		29c. License numl			I. Date signed (Month		
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	1	-	30. Name and address of person who co				Mp1 -	a 0115			
	State	3	Tariq Mahmood, M. Bate filed (Month, Day, Year)	<ol> <li>19 Ridge</li> <li>32. Registrar's Sig</li> </ol>		Westminster,	Marylan	d 2115	) /		
	Registra	_	JUN 1 7 2010		back	/					

DHMH 17 Rev 7/2009

Amend #17, Please Type or Print in Black Indelible in Francisco State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DOROTHY ANN HALL  $\mathbf{A}^{\mathsf{M}}$ Medical JUNE 2010 2:14 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 8755 Contee Road, Apt. Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🗓 F (Month, Day, ) March 28 Country)
Maryland Director Yrs 579-50-6144 73 1937 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8755 Contee Road, Apt. 201 20708 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian. Armed Force ò ģ 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ø Clerk Typist Dept. of Defense Be 17. Father's Name (First, Middle, Last) **Ashbury** 18. Mother's Name (First, Middle, Maiden Sumame) မှ Burt Hamilton Lucille Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Dwayne Edward Hall/Son 7804 Old Ardwick Ardmore Road, Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 6/29/2010 1 Burial 2 Cremation 3 Removal from State Heritage Memorial  $\frac{6/19/2010}{}$ 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immedia Cause (Final Onset and Death Ph\_sician/ Vulvar Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe After this certificate ☐ Yes 2 🛛 No 1 ☐ Yes 2X☐ No or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 🗀 Inpatient 2 🖂 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 🗆 Yes 2 🗆 No 5 Pending 2 Accident
3 Suicide
4 Homicide within 24 hours after death To the Funeral Director: completed filled in by the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital ledical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and Me 29d. Date signed (Month, Day, Year) 10 D42580 June 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parmjit Singh Aujla MD 5632 Annapolis Road, Suite 13, Bladensburg, MD 20710 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #17, Sper DWR 9904 6/24/10 TT. State of Maryland Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy W. Hall Month 10:1574 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death . County of Death Baltimore Washington Medical Center en Social Security Number Funeral 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 149 22 6145 1 □ M 2 🕱 I Months Hours Min (Month, Day, Year) 01/04/1931 Director 79 Mary land Usual Residence of Decedent 10a. State 10b. County 28a-f sho 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a Maryland Anne Arundel Glen Burnie 1 🗆 Yes 2 🏿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Chalmers Avenue 21061 U.S.A. ural", or items ? LExaminer mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Mode1 Self Employed Be 17. Father's Name (First, Middle, Last) Curtis Whitehead Department of Health and Mental h Important: If item 27 is marked any any injury or act. and Mental Fishers is marked of 18. Mother's Name (First, Middle, Maiden Surname) Curtis Whitehead Margaret (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Hall / Son 6049 Newton Road Preston, Maryland 21655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 06/15/2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Filiysician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any hading to immediate Examine Dix-10 (or se a coneccuence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events and -trans Due to (or as a consequence of): burialresulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : g ☐ Unknown 2 No the detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, The law requires 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director. After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Notes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWUSH ROM 31. Date filed (Month, Day, Year) 32. Registrar State JUN 1 7 2010

DHMH 17 Rev 7/2009

Registrar

			Pleas	e Type or P AMEND I State of I em I per o	rint in Bla TEM#8pe Maryland	ack Indel	ible Ink.	Ensure A	All Copies A	Are Legible	
			Registrar AMEND #5	PER INF GS	908 10/0	,077157 7 Pertifiq	ate of De	eath		J. No.	0001
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and the second	Funeral Director	ner		HOSPI Sex 1 M 2 D F	Ha/ Age (In yrs. last b	_ K	anda der 1 Year	ocation of Death    S	8. Date of Birth	4c. County of Deat	th  More  Thiplace (State or Foreign  Lingty)
	*		Usual Residence of Decedent  10a. State  10b. County	6					UCT 1	<del>/94/+</del> ///	ary land
	the Maryland or 28a-f show e notified at	Director	10a. State 10b. County		Gw	V///	Oak Zip Code		100	Citizen of What Co	10d. Inside City Limits  1   Yes 2 □ No
	h with the ns 23a const be	Funeral	6810 Eastria	ge K	oad	101.		207	100	Jnited of What Co	States
9600	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	至	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s? <b>X</b> No	If Yes, s	cedent of Hisp pecify Cuban, s 2 <b>X</b> No	anic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	iled within 72 hours aff I Hygiene. other than "natural", rent, the Medical Exa	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)			Sa. Decedent's U (Give kind of life. PONOT	work done dur	on ing most of work !/er	ing 16	Sb. Kind of Business $\mathcal{C}\mathcal{S}X$	Industry Inc.
Maryland	should be filed h and Mental Hy 7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last	UnK.			1	8. Mother's Nam	e (First, Middle, Mai 1 le len	den Surnarge) Kem	O
Man	12 shoul lith and I 27 is ma r trauma		19a. Informant's Name/Relationship	Type, Print)	15 de la 15	9b. Mailing Addr	ess (Street, and	Number or Rura	al Route Number, Ci	ty or Town, State, Zip	Code)
Baltimore,	40 <del>4-</del> 1-		20a. Method of Disposition  1 M Burial 2 Cremation 3	Removal from Sta	te cemer	of Disposition (fitery, crematory of	r other place)			c. Location - City or	Town, State
Baltir	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		_ Wo∝	dlawn C	emeter and Address	y 6-19 Facility reene	10 10	Services	(21ZZg)
	hysician/ Medical	5 3	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	sed the death. Do	al i	ode of dying, s	such as cardiac of	or respiratory arrest,	al PIRC	Approximate Interval Between Onset and Death
0	(a) Fig. (b)	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. — Due to (or a	s a consequence	e of):					
. Box 68760	Attending Physician: The law requires that the death certificate be refeath. sctor. After this certificate has been signed by the attending physici. by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 D Fetal dea t at time of death		c pregnancy (specify)			23d. Date of del Month	livery Day Year
Js, P.O.	v requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death	but not resulting	g in the underlyin	g cause given	in Part I.			the cause of death?
Recor	The law recrate has bee page 2 sho	Completed							24a. Was an autopsy performe 1 □ Yes 2	prior to d	topsy findings available completion of cause of
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital:			Other:	of Death (Check	( only one)	No	JON CO
) of	ling Phy I. After this uneral d	ate: To	27. Manner of Death 1 □ □ □ Pending	28a. Date of in	atient 2 ER/C ljury 28b. Day, Year)	Time of injury	28c. Injury at work?		me 5 LJ Residenc 28d. Describe how i	e 6 Other (Speci njury occurred	ify)
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page:	1						28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Director Completed filled in I	Medical	(Check 2/\( \) Medical Exam	vsician: To the best on niner: On the basis of se Practioner: To the	examination and	or investigation.	in my opinion, a	death occurred at	the time date and n	lace, and due to the o	cause(s) and manner stated
	within comp		29b. Signature and title of certifier	Se Mactioner 10 th	le best of my know		9c. License nu		29d.	Date signed (Month	, Day, Year)
		-	30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)	V/_	0 /	0	Une 19	6, 2010 Le 106,
co <sub>2</sub>	CI-		31. Date filed (Month, Day, Year)	BUB (	nn 6 tar's Signature	934	Au	1952	3 131	od Sus	X 106,
	Stat Registra	-	IIIN 17		nais Signature	h ha	1.1				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day ohnsor PM iane 0 /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square 5. Social Security Number | 6. Sex Roseda HOSPI more 7. Age (In yrs. last birthday) If Under 1 Year 24 Hrs. 8. Date of Birth Min. (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 W Months Hours **Director** Mary land Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at Director 1 Nes 2 No Tonore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 NO 21215-0036 1 ☐ Yes 2 ☑ No Specify ۾ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than use retired) Elementary/Şecondary (0-12) Health and Mental Hygiene. College (1-4or 5+) Trder Baltimore, Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any Injury or other trai once. daughter 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature Ameral Service Licen Howell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0515 /Medical Due to (or as a consequence of): Examiner aritonea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature apd title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, MD 21237

9000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 50 AM une 2010 16 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street 4c. County of Death Examiner Nontgomer Home >1/Wer If Under 1 Year | If Under 24 Hrs. Birthplace (State of Foreign Country) Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months 1□ M 2 🖫 Days Hours Min Korea Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar 28a-f show Examiner must be notified at 1 Dres 2 No **Funeral Director** ton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 N6 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Monce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ODD 2 10 19a, Informant's Na Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service License Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE CINKNEWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s certificate dementia 1☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 X No 1 Tyes 2 ER/Outpatient 3□ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural
Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 Suicide 6 □Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) how de D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD: 15216 DINO DRIVE; BURTONSVILLE, CHOWDINGRY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year  $P^{M}$ George W. Kromer Tiine 2010 9:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Park Hall Drive Laurel Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. May 20, 1920 XX M 2 T F Months Director Yrs 579-14-8718 90 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Prince George's Laurel 10e Street and Number ms 23a or ō 10f. Zip Code 10q. Citizen of What Country? Funeral 6716 Park Hall Drive 20707 items 12. Was Decedent Ever in U.S. "natural", or iten edical Examiner r 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 2 🗆 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. U.S. Dept. Elementary/Seconday (0-12) College (1-4 or 5+) 12th of Agriculture Economist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental h မှ George W. Kromer Matilda Reich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Attach Flo Jordan Kromer/Wife 6716 Park Hall Drive, Laurel MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 6/23/2010 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury vears Examine Due to (or as a consequence of): certificate be executed Coronary Artery Disease 10 years that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 talor Attending Physician: The Jaw American attending physician Physician/Medical Renal Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ the Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Day Year Pregnant at time of death 2  $\square$  No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes မ eral Director: After this filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury Acciden
Suicide Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number

Registrar DHMH 17 Rev 7/2009

State

W

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GREBABELT MOZITTO

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

09 32. Registrar's

MGH

31. Date filed (Month, Day, Year)